TRICK

or

TREAT

a survival guide to health care

K.R. Sethuraman, MD.

EQUIP

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TRICK or TREAT
A Survival Guide to Health Care

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Dedication

"By making Doctors tradesmen, we compel them to learn *the tricks of the trade*."

George Bernard Shaw (1906)

Dedicated to
G B Shaw, the visionary author of
'Doctors' Dilemma'

and

Those dedicated and unsung physicians of the World, who fight against all odds and continue to provide ethical and rational health care.

CONTENTS

FOREWORD

"Trick or Treat - a survival guide to health care" is an insider's account of the goings on in the health care delivery system today. It is also a timely wake up call to the health professionals to shape up or face the danger of reaching a point of no return.

The book is blunt in laying bare thorny issues. It is at times brutal. And it hurts as Truth often does. One may or may not agree with the author but no one can ignore the issues involved. The parables are more than apt appetisers. They set the tone and to some extent, cushion your mind from the shocking revelations that follow in the first section.

Though highly critical of the health care system in certain places, the book as a whole is balanced and logical. There is no antipathy to any system of Medicine and the author strongly advocates a holistic approach to health care.

It seems a paradox that when doctors' diagnostic and therapeutic competence have increased tremendously, their rapport with patients have plummeted to abysmal levels. But what else can one expect when terms like `Health-care Provider, Consumer and Health Industry' have replaced `Doctor, Patient and Hospital' respectively? Today, an MD in a hospital denotes the Managing Director rather than a Doctor of Medicine. The term patient comes from patior ("I am suffering"). How appropriate is the word today when a

patient is not sure whether the innumerable tests and treatment procedures are really intended to relieve his illness and suffering or to keep the Industry healthy!

Long years ago, an American journalist named Miss Mayo wrote a scathingly critical book on India called "Mother India". Every Indian was upset. When asked his opinion on the book, Gandhiji said, "Every Indian should read it and no foreigner should."

I am tempted to say that every doctor should read "Trick or Treat" but no patient should. But then this book contains valuable guidelines to patients. It also gives them a `ring side view' of the current health care scene. The lay public would gain valuable insight into the functioning of the health industry and why it has become ruinously expensive. To paraphrase Churchill, "Never in the history of Medicine have so many done so much for so few with so little result."

I have known the author Prof. Sethuraman since his student days. He is a polymath with a Shakespearean breadth of vision. Behind his calm exterior lies a subtle sense of humour evident throughout the book. I am sure that this painstakingly compiled book will have universal appeal.

Prof. S. CHANDRASEKAR, M.D.,
Former Director, JIPMER,
Pondicherry, India.

PREFACE

During my childhood days, I used to wonder, "What makes a doctor tick?" It was a consequence of seeing the adulation my father received and the respect he commanded as a family doctor. He practised in a village called Anaimalai in Tamil Nadu. Later, as a medical student, I was awed by the complexity of human response to health problems. It was as exhilarating as it was unpredictable. If you dug deep enough, every patient had a tale to tell you; every case was a lesson to learn from. Since then I have zealously jotted down these case histories in my diary.

Over three decades, I have collected several vignettes that highlight different facets of illness and health care. I have been sharing these with my students, my patients and health activists. While some of these narratives make their point effectively, a few others agitate the audience into a state of cognitive dissonance. This happens because each facet of the complex issues in health care is unique and needs a proper perspective to comprehend it fully.

Moreover, some facets of health care are diametrically opposite to each other and are in conflict. Some of them are, felt need versus real need, illness vs disease, faith vs reason, expectation vs experience, risk vs benefit, and cost vs benefit in health care. To maximise understanding, I needed to present the vignettes not in isolation, but in the proper perspective. This is where Aesop's fables, uncle Remus tales and Indian folklore came to my help.

These fables and folk tales are clear cut, brief and effectively make their point. Each of them helps us to align ourselves to see clearly, one facet of a complex whole. I have juxtaposed every clinical vignette with a fable that carries a similar message to enhance understanding and reduce dissonance. They are arranged under three sections to highlight the issues, character and coping mechanisms in health care.

I have enjoyed creating this fifty-two faceted crystal. I hope you will appreciate it too, facet-wise and as a whole.

Dr. K.R. SETHURAMAN

Pondicherry, India
January, 2000

SECTION - I

ISSUES IN HEALTH CARE

"The issue is not whether the country has a sufficient supply of physicians, but if the physicians are congruent with our country's health needs."

(R.G. Petersdorf, 1990)

1. The End justifies the Means (*"Your uterus at any cost"*)

The Wolf and the Lamb: *A wolf cornered a stray lamb and felt compelled to give a reason to justify devouring it. The wolf complained to the lamb, "You insulted me last year." The lamb bleated, "That is not possible, Sir, for I was not born then." "Well. You feed in my pastures", retorted the wolf. "That cannot be, Sir," replied the lamb, "for I have not started eating grass." The wolf raised his voice and said, "Then you must have drunk water from my spring." "No, Sir, I have not yet drunk anything but my mother's milk," said the poor lamb. The wolf ran out of plausible excuses and said, "Well, I am hungry. I have to eat you anyway." He then pounced on the little lamb and devoured it.*

Sheela, a 30-year old teacher with pelvic pain, went to her gynaecologist for follow up advice. He had a cursory glance at her case notes and said, "The next step is obvious. Your uterus has to be removed. I shall do it next week."

Sheela started hesitantly, "But doctor, ..."

The doctor said, "Why do you hesitate now? You have severe pain every month."

Sheela: "The pain is now controlled on medicines and ..."

Doctor: "Moreover you have two kids already. Why do you need it anymore?"

Sheela: "No doctor, I would like to avoid surgery if ..."

Doctor: "No 'ifs and buts', Sheela. You don't understand. With ageing there are risks of getting tumours. Why not eliminate the risk and be happy?"

Sheela: "But, doctor ..."

Doctor: "No more questions, Sheela. You bring your husband tomorrow. I shall finalise with him and do you next week."

Comments

"You don't need a hysterectomy. It can do you more harm than good. These are strong words but the fact is that more than 90% of hysterectomies are unnecessary and worse, the surgery can have long lasting consequences. It is time we doctors stopped disassembling women. But nothing will change until more women look their doctors in the eye and *calmly state their determination to remain intact*." (Stanley West, 1994)

A senate committee of the USA has reported that 2.4 million unnecessary operations were performed there at a cost of four billion dollars (equal to 14,000 crore rupees) every year! If a hospital had a watch dog committee to check if surgery was necessary or not, the rate of surgery declined by two-thirds. (Fulder S, 1991)

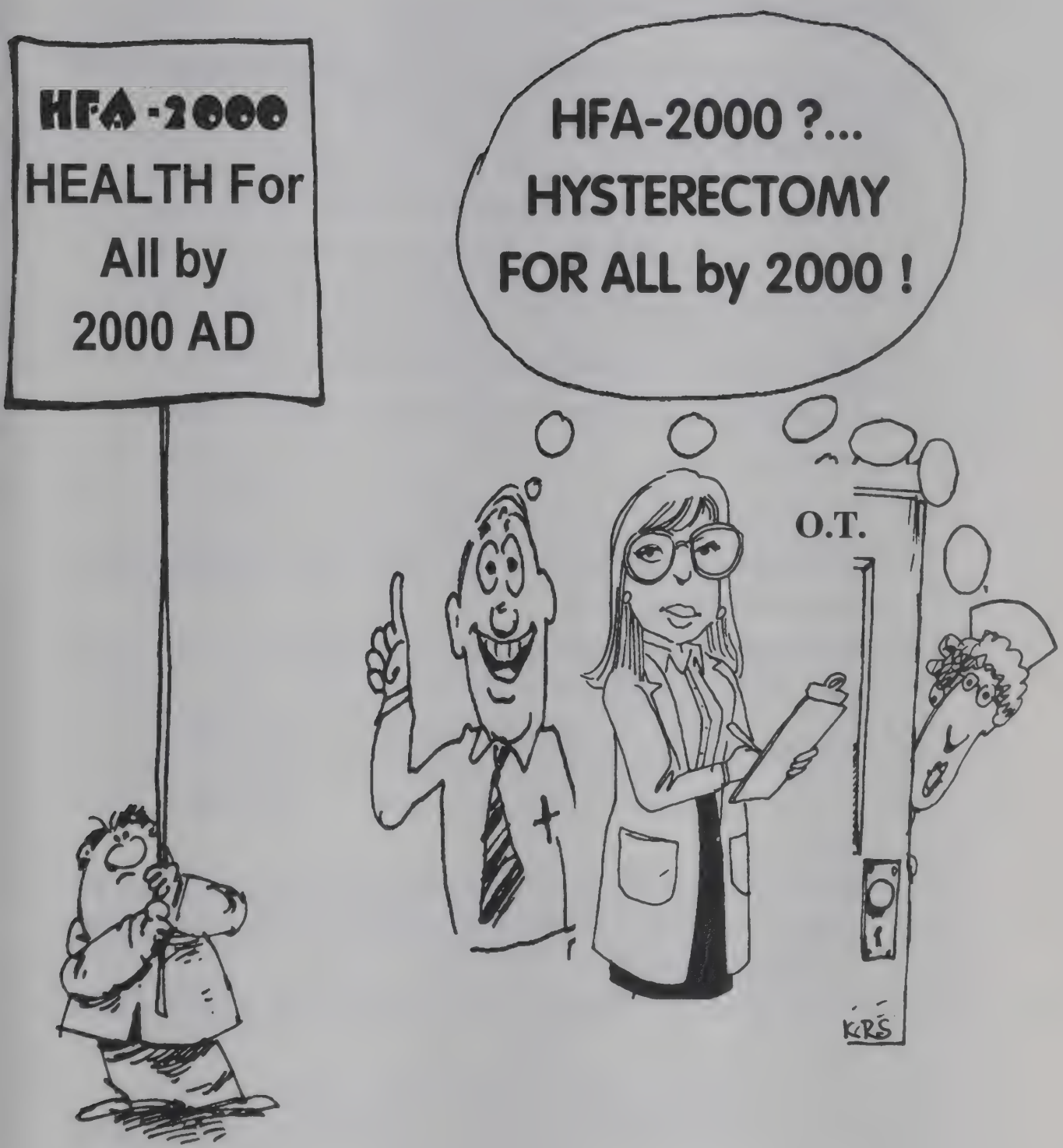
This is the situation in US where health care seekers (patients) are generally aware of their rights and play an active role in medical decision making. One can then imagine the plight of an average Indian patient who unquestioningly accepts any medical advice as the gospel truth. I have come across many young women in their 20's who have had hysterectomy done. The general tone of medical advice for the surgery has been, "You have had your two kids. You do not need your uterus anymore." My colleagues working in gynaecology say that most of these unfortunate cases could have been managed without such a drastic step.

Doing a Caesarian section giving little chance for a normal delivery to occur is another act of taking young women on an unnecessary 'surgical ride'. Scientific studies in Maharashtra state have shown that *it has little to do with medical indications and every thing to do with money*. In these studies, the professional fees were fixed for every delivery conducted, regardless of its mode (normal or surgical). There was a significant reduction in the rate of Caesarian sections and a proportional rise in normal deliveries.

Removing the tonsils used to be a 'surgical epidemic' earlier. The ear-nose-throat surgeons are more conservative now. Due to the ease of laparoscopic surgery and the income generated by this hi-tech procedure, the gallbladder and the appendix have become the current victims. I find it hard to believe that even removal of the eye-lens has succumbed to the market pressures. My ophthalmic colleagues say that they have documented cases who went to a hi-tech ophthalmic centre with *presbyopia* (age-related problems of near vision) to be advised 'urgent intra ocular lens implantation'.

Bernard Shaw, in the preface to his famous play 'The Doctor's Dilemma', has made the following observations which were scandalous in 1906 but are entirely appropriate today.

"It is not the fault of our doctors that the medical service of the community, as at present provided for, is a murderous absurdity. That any sane nation should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. But that is what we have done. It may also be necessary to hang a man or pull down a house. But we take good care not to make the hangman and the house breaker the judges of that. If we did, no man's neck would be safe and no man's house stable."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HEALTH For
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O.T.
KRS

Taking charge of decisions

If you want to be an informed seeker of health care, discuss the following points with your doctor before agreeing to undergo any procedure:

1. What is actually wrong with me?
2. How serious is this disease/condition?
3. What may happen to me if I leave it untreated?
4. What kind of procedure are you planning to do?
5. Is the procedure being done for diagnosis, for treatment or for both?
6. What are the risks of this procedure?
7. What are the chances that the proposed procedure will be successful in my case?
8. Will the benefits of surgery last long, or is it just a temporary measure?
9. Are any alternate procedures/treatments available?
10. Of these, which do you think would be the best for me? Why?
11. If your relative were in my position, would you choose the same for him/her? (If there is a difference between 10 and 11 please explain it.)
12. Could you suggest any source of information on this disease that I could read or watch?
13. What is the total cost of the procedure likely to be?
14. Is there any follow-up costs involved after the procedure?

It is good to take a second opinion before taking major decisions (see ch. 36). An ethical doctor would welcome it.

2. Debt: Mine or Yours?

The Fox and the Goat: *A fox slipped into a deep well by accident. He was wondering how he could get out. Soon a thirsty goat peeped in and asked if the water was good. "Excellent," replied the fox, "it is very tasty. Come in and try it out for yourself." The goat jumped into the well and quenched its thirst. When he started wondering how to climb out, the fox told him, "You stand on your hind legs and put your forelegs on the wall. I shall climb on you and get out. Then I shall help you out." The goat did as he was told and the fox climbed out. He told the goat, "To help myself out, I had to get you into the well. Thank you for being so gullible," and ran away.*

Ammasai, a 40-year old petty businessman, went to a newly started posh clinic for consultation. After examining him, the consultant said, "You got chest pain. It could lead to a heart attack. We can't take chances. Get admitted now," and sent him to the ward.

After a while, the admitting doctor approached the consultant and said, "Sir. He is not rich. He says he had to take a loan even to pay the consulting fee. Should we have to admit him? After all, he seems to have only pectoral myalgia (a form of muscle ache of the chest)."

The consultant replied, "Don't be silly. Grow up. You are worried about other people getting into debt, but what about the loan I have taken to build this clinic? I am in a deeper debt than you know. Just admit him. He will get the money from somewhere."

Comments

'The Mercenary doctor' is not a modern phenomenon but has been a problem over many centuries. "A doctor who can help a poor man and will not (do so) without a fee, has less sense of Humanity than a poor ruffian who robs a rich man to supply his necessities. It is something monstrous to consider a man of liberal education tearing the bowels of a poor family by taking for a visit (as fee) what would keep them for a week," lamented Richard Steele (1672-1729). In Sanskrit, there is an ancient couplet which says, "A physician is the elder brother of Yama, the Lord of Death, because Yama takes away only your Life but the physician takes away your life and all your money!"

Bernard Shaw had an uncanny insight into the working of a doctor's mind when faced with the dilemma of choosing between ethics and monetary compulsions. He wrote thus in his preface to The doctor's dilemma:

> "As to the honour and conscience of doctors, they have as much as any other class of men, no more and no less. And what other men dare pretend to be impartial when they have a strong pecuniary interest on one side?"
>
> "It is simply unscientific to allege or believe that doctors do not under existing circumstances perform unnecessary operations and manufacture and prolong lucrative illnesses."
>
> *(Bernard Shaw, 1906)*

I know of countless number of true stories from 'fee for service' hospitals. The pressure to bring in income by unethical means is much higher in hospitals run for profit by nontechnical financiers. I am sure every reader of this book will have a tale to tell in which a friend or a relative was taken on an expensive

'medical ride'. In Chennai, there was a feeble attempt during 1999 to curb unnecessary laboratory tests but greed and pragmatism prevailed; senior medical professionals have confided in me that about 30% to 50% of tests are perhaps unnecessary for patient care but are done to keep these centres financially viable.

DOCTOR'S LOAN BECOMES PATIENT'S DEBT

One of my students, who had joined a private hospital in a metropolis, could not stand the commercial exploitation of human gullibility and fears that took place there. He said this about his experiences: "No pregnant woman had a chance of a normal delivery during the second half of every month because money had to be generated to pay back the next monthly instalment to the bank. Similarly, any one with any sort of chest symptom would be put into intensive care and kept there for five days unless they ran out of money and asked to go home." When my student raised some ethical queries, he was simply told to *join in or get out*. He chose to get out.

I have debated this issue of 'exploitation' with some of my friends in the private sector. They disagreed and argued thus: "Most patients are happy getting the maximum attention, we are happy collecting our fees and the health care industry is happy generating income. It is an all-win situation. Why should *you alone* be unhappy?"

This seemingly benign rationalisation had me cornered for some time before the viciousness of it struck me. Then I asked my friends, "A drug peddler or a pimp will also use the same logic and say it is an all-win situation. Can you or the society accept it then?"

The harsh reality is that two-thirds of our rural families are in debt because of health care expenditure. The urban figure will be no less than that. "Until the medical profession becomes a body of men *trained and paid by the country to keep the country in health*, it will remain what it is at present: a conspiracy to exploit popular credulity and human suffering" *(Bernard Shaw, 1906)*.

If the shackles of health care related indebtedness has to be broken, the planners and health activists have to squarely address this issue and find some lasting solutions. I believe that the Munnar model discussed below is a credible alternative.

3. Ruinous health care

The Horse and the Groom: *There was a groom who took pains to clip and comb the horse under his charge. Daily he stole a portion of the oats meant for the horse and sold it for his own profit. Despite all the grooming, the horse looked thin and unhealthy. At last the horse cried to the groom, "If you want me to be agile and healthy, comb me less and feed me more."*

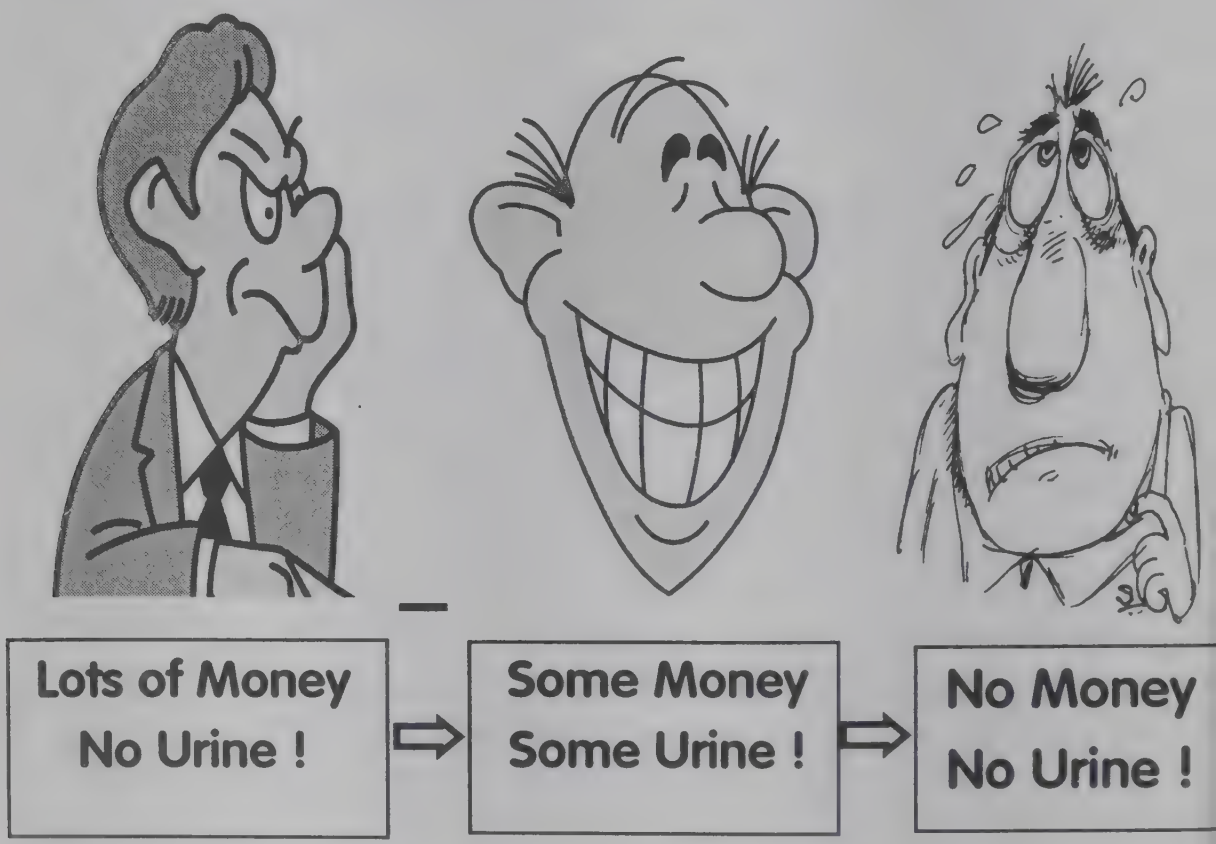
A farmer was detected to have diabetes mellitus. The treating doctor did frequent tests to control his sugar levels and prescribed many expensive medicines. This ruined the farmer financially and he worsened despite the "good care." At last the farmer cried to the doctor, "If you really want me to feel well again, you must care less about my diabetes and think more about the basic needs of my family."

Comments

It is estimated that about two-thirds of rural families are in debt because of health care expenditure (Phadke A, 1995). What is not realised is that this is largely avoidable. Tata group hospitals at Munnar have shown in 1993 that it is possible to treat all the illnesses in their community of about 100,000 people with medicines costing just Rs 30/- per head per year. The total health care expenditure for that year worked out to about Rs 120/- per head. These rates are even lower than the insurance premiums for health care. It is, therefore, possible to deliver appropriate health care to a community at a reasonable cost, even in the 90's. It is a shame that the Munnar model has not been more widely discussed and adopted by other health care providers and planners.

While considering various health care options, an ethical health care provider should be sensitive to the cost factor, and take the patient's opinion on the "3-As" of acceptability, affordability and appropriateness and the "2-trade-offs" of cost versus benefit and risk versus benefit (see ch. 33). One must also recognise 'futzing' and avoid it. Futzing refers to activities that are mere rituals in health care which do not really help in managing a case or in improving the outcome (see ch. 8).

Referring to the inexorable downhill worsening of advanced diabetic kidney disease despite dialysis, Prof SGP Moses of Chennai used to quip, "There are three stages in the terminal phase of diabetic kidney disease: lots of money - no urine; a little money - a little urine; and no money - no urine!"



I find no better way to express the plight of low and middle income group needing expensive treatment that merely provides temporary solution to irreversible or progressive disease. By the time the Truth dawns on them, it is too late (see ch.4). They are in penury or worse still, in deep debt.

As an enlightened health care seeker, you should discuss with your care provider (doctor), the available treatment options and the relative cost-benefit and risk benefit of these options before deciding on the most appropriate and sustainable option.

4. From a frying pan into the fire

> ***The Stag and the Lion:*** *A Stag was chased by hounds, and took refuge in a cave, where he hoped to be safe. Unfortunately, the cave housed a Lion, to whom he fell an easy prey. "How unlucky am I," he cried, "I am saved from the dogs only to fall into the clutches of a Lion."*

A 50-year old man had a muscle wasting disease (muscular dystrophy) for ten years. Presently he was so weak that he could hardly breathe. He demanded and got into an intensive care service where he was connected to a breathing machine (mechanical respirator) through an external opening into his wind pipe. He was now voiceless and powerless. "How awful," he thought, "I am saved from the misery of breathlessness only to lose my voice and fall into the clutches of this miserable machine."

Comments

Patients with chronic and inexorably worsening diseases would eventually reach a stage of needing life support by

artificial means. Dialysis and artificial respiration are two such examples. There are many more ways of jumping from the frying pan into the fire and wonder if you are *extending life or merely prolonging death*!

The ideal way of approaching such a problem is by creative problem solving (see ch. 35). Lesser mortals have to ask the following questions:

1. How will my disease reach its end stage?
2. What are the difficulties I may have then?
3. Am I likely to be mentally deficient or in coma?
4. Will I need any long term treatment to prolong my life (eg. respirator)?
5. How will it (respirator, dialyser, etc.) affect my quality of life?
6. If I undergo such treatment, am I likely to recover?
7. Will aggressive options really extend my life or merely prolong the dying process?

Complex treatment options and high-tech medicine are often 'half way technologies'. Like moths attracted to flame, care seekers accept these options to prolong their lives. Many of them live with smouldering diseases and disabilities as examples of "failures of successes" (Silverman WA, 1995). Visit any tertiary care hospital and you will see many such *failed successes* who hover between life and death for long periods. Most deaths in a tertiary care hospital setting are orchestrated events because, the dividing line between life and death is blurred.

At times, the relatives of a seriously ill patient have to take decisions on continuing artificial life support and on donating organs for transplant surgery. The following questions may be

discussed with the doctors:

- What has happened to him/her?
- How serious is the condition?
- Is he/she in pain?
- Is he/she in coma? Is the coma reversible? How long will it take?
- Is he/she brain-dead? When will you know?
- Does he/she on life support (like respirator)? Can it be ever weaned off?
- If he/she recovers, what is the likely residual damage?
- What would you advise at this point?
- Would you be kind enough to tell us what decision you would take if your friend or relative (God forbid!) was in a similar condition?
- Should we get other opinions or consult any other specialist?

You should understand the following terms when discussing death and dying.

Physical death: Cessation of all biological activities including those of the heart and the lungs. This is traditional definition of death.

Brain death: Irreversible cessation of the functions of the entire brain. Artificial life support is needed to keep the heart and other organs functioning. Survival beyond a few days is unusual but may go on for up to six weeks. This is also a form of death but the main difference is that the organs of a brain-dead person can be harvested for transplantation. Unethical care providers may give false hope to the relatives of a brain-dead person and continue futile and ruinously expensive intensive care just to keep their beds occupied and generate income.

Persistent vegetative state: Permanent loss of consciousness due to irreversible cessation of higher mental functions like consciousness, experience of pain etc. The person may have sleep-wake cycle that may give a false hope to the near and dear. With good nursing care, such an individual may survive for many months or years. Young females in vegetative state have conceived and given birth to babies without ever being aware of it. With a good nursing care, managing cases in vegetative state is possible even at home or a hospice.

5. The importance of family practice

The Belly and the Members: *Once the limbs felt that they did all the physical work and earned a living to feed the belly. The belly did no work except receiving feeds at regular intervals and sort them out at leisure. The limbs told the belly to look for food by itself. The belly had no option but to starve. The whole bodily system weakened. The limbs realised that they needed the belly to sort out food and nourish them. They realised how foolish they had been.*

As health care became more specialised, the importance of family practice and primary health care diminished. People said "What is the use of consulting a family doctor? He only refers us to another doctor. Why should we go through this sorting office? Why not bypass him?" They began directly consulting a specialist based on their own opinion on what was wrong with them.

The Specialists did not insist on cases coming to them through a referral system as prior handling by "those GPs only complicated the 'scientific management' under the specialists."

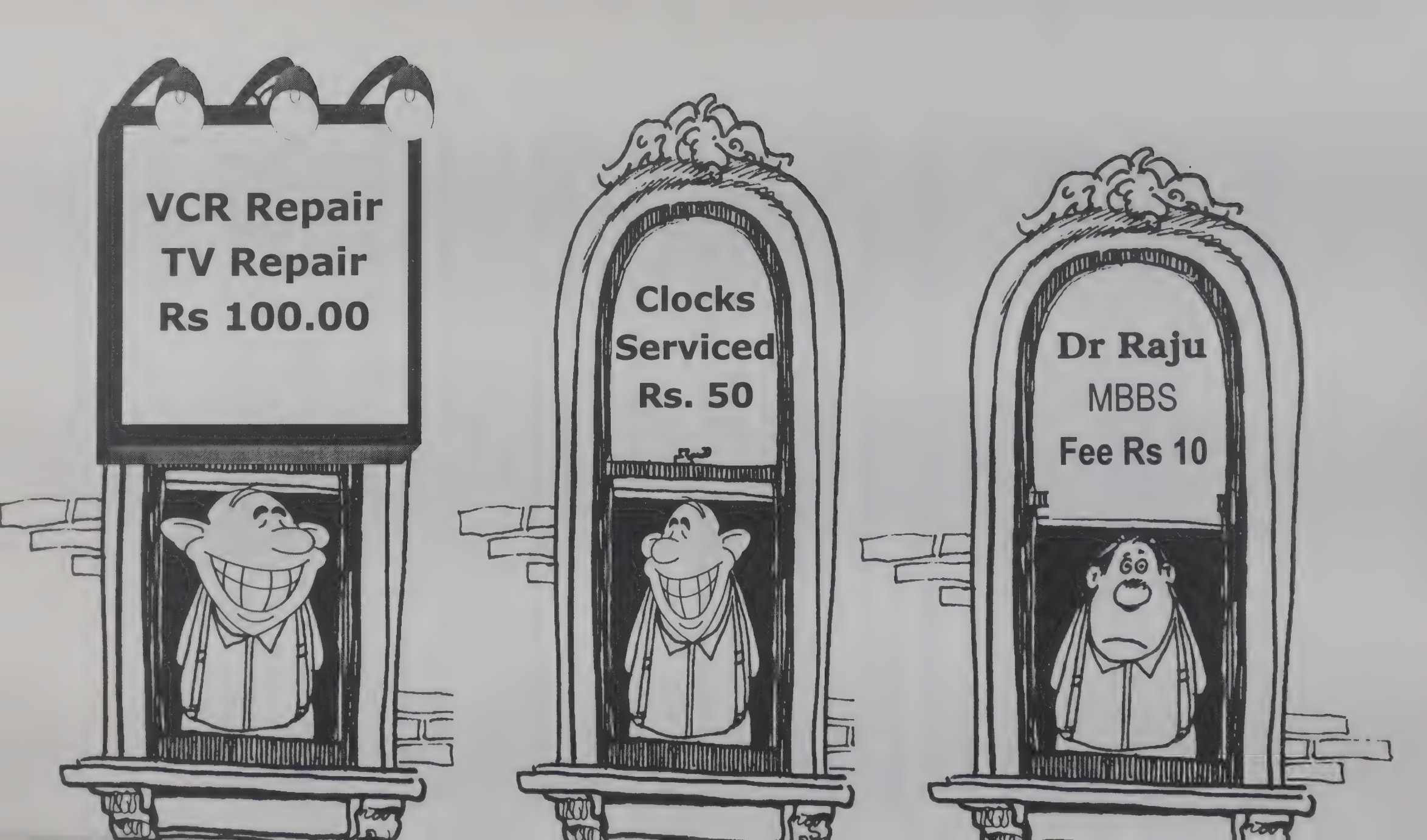
The problem with self-referral was that many care seekers ended up consulting the 'wrong specialist' whose main job was to rule out any diseases concerned with his/her speciality. Soon, the society had a hi-tech, expensive and often wasteful health care system with little improvement in the outcome. People wondered what went wrong.

Comments

Just as the stomach and the bowels have a primary non-glamorous job of breaking down complex food, a primary care provider (family practitioner) has to have a holistic view of a patient's illness and sort out his/her various problems. Sorted out health problems may have to be specifically referred for specialised treatment. In UK, the necessity of screening all patients by their primary care physicians before any referral, has been stressed once again after a recent review of the practice guidelines.

During the 70's and 80's, people in the USA went for specialist treatment in a big way. It was a *disease oriented, procedural, piecemeal approach* that was ruinously expensive and was soon controlled by the insurance industry. Now the society seems to have realised its folly and is reverting to a primary care approach that is *patient-oriented, holistic, continuous and comprehensive*. Do we also have to travel down the wrong path before realising the folly? Can we afford it?

For primary care physicians to develop as "health care advocates" for their patients, they must reverse the current trend and help their patients to avoid inappropriate entry into a specialist care not because they are costly, but because they waste everybody's time, incur unnecessary risks and divert attention from more relevant and effective solutions (Hart JT, 1992).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TV Repair
Rs 100.00
Clocks
Serviced
Rs. 50
Dr Raju
MBBS
Fee Rs 10

The main problem for a family doctor (GP) in India is that it is a lot of hard work to earn by ethical means. People, who are ready to shell out a hundred rupees to get their TV serviced, hesitate to pay a tenth of that amount to a family doctor. There is also the unfair competition from quacks and charlatans. This is by no means a recent occurrence. Even as far back as 1906, Shaw has said, "It is better to be a railway porter than an ordinary GP. The GPs are offered disgraceful prices for their advice and the medicines."

No wonder that all but the staunch idealists succumb to unethical practice and easy money (see ch. 18). We need to find ways of providing a 'level field' for family practice. We need to make ethical family practice worthwhile for the practitioner in terms of the earnings, quality of life and self esteem. Otherwise things can only get worse for the community. The community has to help the family doctor to help them in turn. Who will take up this urgent task?

6. Glamour versus Value

The Stag at the Pool: *A stag felt a sense of pride whenever he saw the reflection of his fine antlers on the surface of a pool. However, he felt ashamed at his slender legs. One day a lion attacked him, but the speed of his legs was more than a match for that of the lion. Unfortunately, his antlers were caught in the branches of a dense forest and the lion pounced on him. The stag thought, "I despised my legs but they almost saved my life. I glorified my horns and they have ruined me."*

A) Palani, a rich elderly farmer was status-conscious and proud of his wealth. He always consumed the best in the market, be it food, liquor, smoke or materials for a comfortable living. One of his grouses was that the village lacked specialist doctors. He often used to taunt his family doctor, "Look at the great specialists available in the city. We only have GPs like you in this village." The family doctor used to say nothing in reply.

One night, while returning home after attending a wedding reception, Palani developed retching, vomiting and stomach ache. He blamed the oily food served at the reception for his current predicament. He ordered his driver to go to the city's top gastroenterology unit for emergency treatment. He was admitted for observation and management. Emergency endoscopy was done and some medicines were given to him for symptom relief.

He went home the next day and had a massive attack with no chest pain but stomach ache. His family doctor came to attend on him. When he recounted the problems of the previous night, the doctor asked him, "Did you not tell the city doctors about your smoking, high blood pressure and long standing diabetes? This is an atypical heart attack. You had the warning signs last night."

The farmer was pensive for a while and spoke in a sad voice, "No one asked me anything there. They did all the tests, gave me some expensive medicines and said 'everything is OK in your belly'. I despised family doctors like you but you could have advised me better than the glamorous specialists. I wish I had consulted you last night. I would have got the correct advice and perhaps avoided the heart attack."

B) During the alumni reunion, Shyam, a tertiary care specialist taunted his batch mate Vivek who was a family practitioner. "Look at the glamour in specialities. Why did you end up as a mere GP?" Vivek replied, "I agree your speciality is more glamorous than mine. But when it comes to lifelong rapport with families, wide ranging practice and professional commitment to holistic care, family practice is the best. You all are *mere procedural robots* who attend to a specific need of a patient at a specific point of time in their life span."

Comments

Specialists know much more about much less. They are essential in providing focused high quality health care to preselected and referred cases. Their services should not be misused by persons with undifferentiated health problems. Undifferentiated problems are initially best assessed by a family physician. "Health care consumption" by direct entry to tertiary hi-tech care causes much 'futzing' (wasteful case management) at times to the detriment of the care seeker.

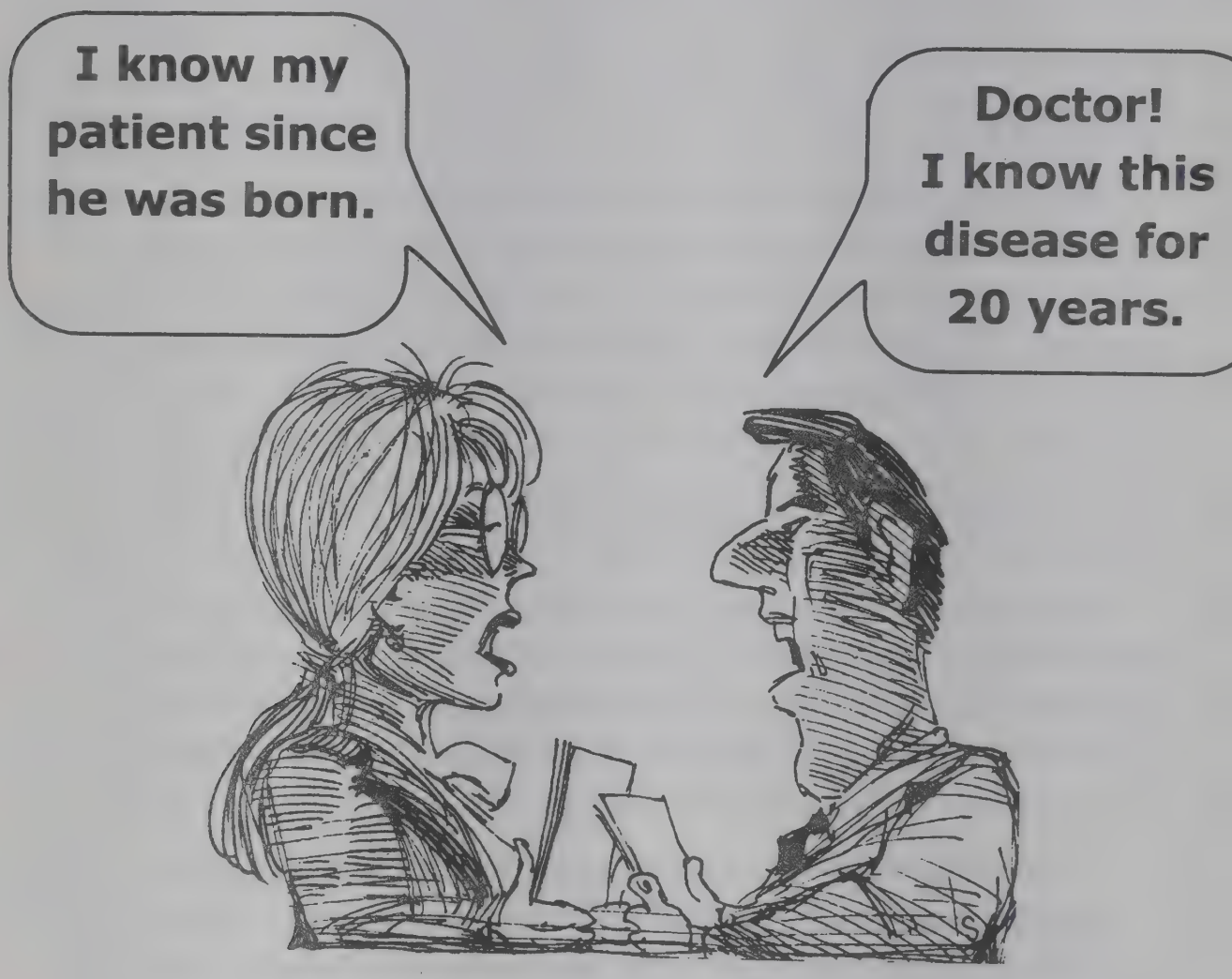
The family doctors and general practitioners (GPs) have an important function to perform though it may not appear to be as glamorous as tertiary care. They should be proud of their ability to deal with primary undifferentiated patients and sort out their problems in a holistic manner (see ch. 52).

The reality of health care is that the patient care becomes more and more disease oriented and impersonal as you move up to tertiary care. In family practice, *diseases come and go but the patients remain with you*; in speciality practice, *patients come and go but the diseases remain with you.*

"There is a need for schizophrenic practice of medicine. The treatment of a disease may be entirely impersonal; the care

of a patient must be entirely personal. The secret of patient care is caring for the patient" *(Dr Francis Peabody)*. A good family doctor can do it well. They are still around.

Get an ethical one for your family today if you do not have one at present.



FAMILY DOCTOR vs SPECIALIST

7. One symptom does not make a syndrome

The Spendthrift and the Swallow: *A spendthrift had spent all his fortune. He had nothing left save the fine woollen clothes on his body. It was early spring and he wondered where his next meal would come from. Then he spotted a swallow and perked up. He thought, "Ah! There is a swallow. Summer has arrived. I do not need these winter clothes anymore," and sold all his woollen clothes. The weather unexpectedly reverted and there was a sharp frost that killed the swallow. When the spendthrift saw the dead bird, he cried, "You foolish bird! Thanks to you, I believed that summer has arrived. Now I am also freezing to death in the cold."*

Velan, a 60-year old man who had been a hypochondriac throughout his life, woke up with hiccups. He remembered a Tamil proverb that states, *he who has hiccoughs, will reach the heaven*. He thought, "I am sure I have some terminal illness. I already feel weak and infirm."

Velan consulted many doctors, underwent very many tests and took various medicines. He spent all his savings on treating the hiccup which persisted for weeks. One fine morning the hiccups just disappeared as unexpectedly as it had started. Velan lamented, "You miserable hiccup! I thought I was going to die and spent all my savings on treatment. Now you have vanished and I am broke!"

Comments

Misusing modern science to pander to myths and superstitions amounts to quackery. Hiccup being a 'killer-symptom' is just one example of such false beliefs. I have seen several gullible persons fall prey to doubts and fears raised by

proverbs, house-lizards, black cats, astrologers, palmists and numerologists.

People are susceptible to such divinatory practices and 'mind readers' because of *Barnum Effect*. This refers to the tendency among people to embrace generalised descriptions and predictions as idiosyncratically their own. Then they turn to modern medical science to quell their fears and phobias. Many medical practitioners are only too happy to exploit the situation as "It is good for the business". Shaw had some telling comments on this: "Without fear and credulity (in the public), half the private doctor's occupation and seven-eighths of his influence would be gone."

Under the pretext of ruling out all the possibilities and allay the anxiety, several tests may be performed. Tests should be critically selected to 'rule in' a disease rather than 'rule out' all other possibilities. The muddled thinking has unfortunately percolated quite deeply into the current medical education and practice. It shows up best during an MBBS examination where the scene is often like this:

Examiner: "So what is your diagnosis?"
Candidate: "Disease XYZ, Madam."
Examiner: "What laboratory tests do you want to do?"
Candidate: "Tests 1 . . ., 2 . . ., 3 . . ., etc., to *rule out the disease XYZ.*"

The student wants to rule out the very disease that has been diagnosed by him! Imagine how judicious he would be while ordering diagnostic tests in medical practice. T.S. Eliot's warning against "*action taken not for the good it will do but that nothing be left undone*" applies to the offensive practice of the so called 'defensive medicine' (see ch. 8).

Once, I admitted an 80-year old man with multiple symptoms of recent onset and a clutch of prescription slips. On thorough examination, he only had moderate anaemia due to hookworm infestation and perhaps had it for several years. He responded well to treatment and visibly cheered up.

At the time of discharge, I asked him why he felt so much concerned about such a minor disease. He smiled and then confided in me, "I also wondered why. Then I remembered it. When I was ten years old, my father had told me that I shall be strong and live till the age of eighty. Then a health crisis may occur and if I could survive that, I shall live for a decade more." He had forgotten all about it but the fear had survived in his subconscious mind and taken its toll after seventy years. This form of 'hex death' like situations are common in rural India even today.

Informed and enlightened individuals should break the shackles of age-old myths and superstitions and become truly autonomous. Social and health activists have to join hands to reduce the gullibility of the community and to reduce the current practice of defensive medicine.

8. Chasing "the tar baby"

Brer Rabbit and the Tar Baby: *One day Brer Fox got hold of some tar and made a Tar Baby. He put a hat on it and set it in the middle of the road. Then he hid behind a bush to see what would happen. Presently, along came Brer Rabbit. He politely wished the Tar Baby, "Good morning." When it did not respond, he wished it repeatedly. Finally, thinking that the tar baby was being deliberately rude, he punched it in the face and of course, his hand got stuck in*

the tar. He punched it with the other hand and that hand too got stuck. When he tried kicking it, his legs got stuck. It was then easy for Brer Fox to capture Brer Rabbit.

Ms Mary was a 30-year old staff nurse in a hospital. She had 'heart burn' for a long time. She was treated with dietary changes and antacid gel whenever needed. One day, she decided to get an ECG done just to make sure her heartburn was not a heart problem, but only due to acid reflux. The ECG showed "nonspecific T-wave abnormalities."

Mary got alarmed and consulted a cardiologist. He advised a treadmill-exercise-ECG "to rule out ischemic heart disease." That test showed a 'nonspecific or borderline abnormality'. She was advised angiography to study the blood vessels of the heart. As this procedure involves the passage of plastic tubes (catheters) through blood vessels into the heart, she was in a dilemma: whether to accept the uncertainty or get the invasive test done. She went back to her family doctor for advice.

Her family physician, on learning all the details, laughed and said, "Sister Mary! You have got trapped in the *tar baby syndrome*." He counselled her against any further tests and to continue the treatment for heartburn.

Comments

All enlightened health care providers and seekers have to be aware of the Tar-baby. Drs Mold and Stein (1986) first discussed a similar phenomenon. They used the label "cascade effect" to describe a process that, after a triggering event, progresses inevitably and inexorably to its inescapable conclusion. Dr Patrick Ober (1987) related this to the Uncle Remus story outlined above. One could also cite the story of Don

Quixote chasing the windmills as another example.

How does a clinical cascade or chasing a windmill begin? A physician, or at times a patient, may be goaded by anxiety and frustration, the same stimuli that provoked Brer Rabbit to kick the tar baby and Don Quixote to chase the windmills. In Ms Mary's case, the desire to allay her own anxiety, to feel in control and to overcome uncertainty prompted her to get an ECG done, a seemingly benign and safe action. However, it turned out to be a wrong step that set in motion, a cascade of chain reactions that got progressively more risky and more expensive. A specialist might even have done angiography on her because, *most doctors unfortunately use laboratory tests for support rather than illumination.*

The myth of "laboratory proof" has to be realised by all, especially the professionals. Very few tests can make or break a diagnosis by giving absolute proof that a disease is present or absent. Most tests only affect the probability of a disease being present or absent (the likelihood ratio).

Typically, 95% of population will conform to the range of "normal value" of a test. This is because the way "normal range" is defined whenever a test is first developed. It also means that *5% of normal population will have values beyond what is considered normal for the test.* They are labelled as "false positive" cases. One should realise that the person is normal and test is false positive. Therefore the result is to be discarded in such cases. But this is more easily said than done.

Such a test may cause havoc if used in community with a low prevalence of the disease. If the disease is so rare as to affect one in 100,000 of the population, blind screening for the disease using the test will pick up 5000 normal persons (5% of

100,000) and one diseased person as 'abnormal'. We shall end up with 5000 false leads for every 'true-positive' case detected by the screening! That is a real-life needle-in-the-haystack situation!

Mindless screening tests thus initiate clinical cascades. A battery of 12 biochemical tests done by auto-analyser will produce at least one false positive "abnormal" result in 46% of healthy persons. A 20-test battery will produce abnormal (false positive) results in about 64% of healthy persons. It is indeed quite easy to "kick the tar baby" and initiate a clinical cascade of further tests (Griner et al, 1981). The so called "master check up", if done in a routine manner, creates clinical cascades. It is good for the health care industry and its profits but what about the poor confused *false positives* who run in to a crisis of uncertainty?

This is what happened in the case of Ms Mary who had reflux of acid form the stomach causing heartburn. ECG commonly shows nonspecific changes (of the T-wave) especially in anxious persons. The probability of ischemic heart disease (blood flow problems in the heart) in a 30-year old woman, without any predisposing factors like smoking, diabetes or high blood pressure, is extremely low. The choice of exercise ECG and the interpretation of "nonspecific abnormality" were not warranted in her case because, the test has a false-positive rate of about 25%. She had such a low probability of ischemic heart disease that the odds of that test being a false-positive is nearly 100%. Then why do such a misleading test on her unless one wants to get stuck to another tar baby?

The plain truth is that clinical practice is a treacherous pathway lined with potential tar babies. We may order a

laboratory test for one reason but it may be abnormal for a completely unrelated reason. *In diagnostic testing, more is not necessarily better.*

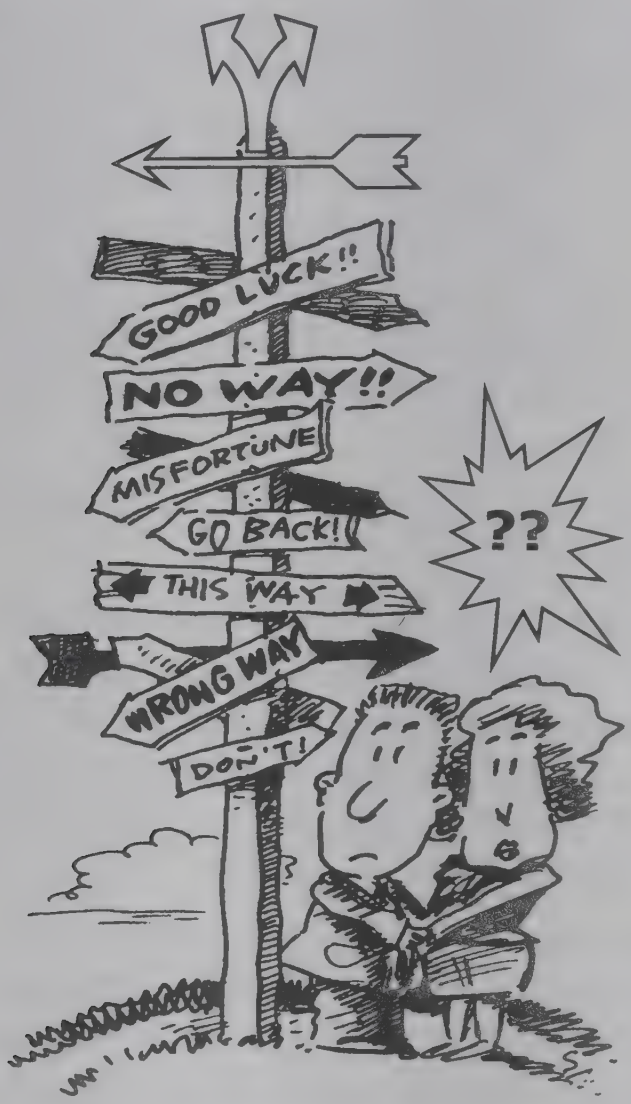
Let us look at the case of Aparna, a 40-year old housewife, with low backache. Her husband, a bank manager, took her to various specialists who ruled out serious diseases relating to their specialities. Since his bank would fully reimburse all the medical expenses, he took his wife to a corporate hospital where a "complete work-up" was done. There was no abnormality in her pelvis or the back bone but a scan image showed a *suspicious area* within her liver. She was advised to undergo a needle biopsy that was essential to clinch the diagnosis and carried only a negligible risk of dying of about 1:3000! Then the couple went back to their family physician for guidance. He advised her, "Just monitor your body weight and forget about any further test for at least six months." She has remained well for the next three years of observation.

Tar baby syndrome results in many avoidable health care processes and ultimately leads to a poor outcome. Despite the common wisdom that lighting a single candle is preferable to cursing the darkness, "In a fireworks factory, it is better to curse the darkness than to light the wrong candle" (Silverman WA, 1980). Tar baby becomes a land mine in such a setting!

Two situations in clinical practice resemble a fireworks factory when it is better to keep quiet than 'light a candle' by ordering tests. The first and the most obvious situation is where, no matter what the result of the test turns out to be, the case management will not be altered. An example will be a case with terminal cancer of incurable type where investigating the primary source of the cancer is thought to be pointless. The

other situation is where the probability of disease is so low that the proposed test is useless as a diagnostic tool. Ms Mary's case is an example of this.

Dr Ober pointed out the real culprit in tar baby syndrome by quoting Pogo, "We have met the enemy and he is us."



CLINICAL PRACTICE -
CONFUSING PATH

9. Follow me

The Fox without a Tail: *A fox was ensnared by a trap. In his desperate attempts to escape from the trap, he lost his tail. He thought that others would ridicule him unless he glorified the loss. He called a meeting of all the foxes in the vicinity and advised them to cut off their tails. "The tail is ugly, heavy and gets dirty. It is good to be rid of it," he explained. But one fox observed, "My friend, if your tail had been intact, you would not be so keen to get our tails removed."*

Meera was a health and fitness freak. She read about the health giving powers of pyramids. She thought, "Why not a pyramid for myself?" and constructed a four-metre tall pyramid in her garden. It had a central chamber where she used to sit and 'gather neutrinos and other health giving cosmic rays'.

Her neighbours and friends asked her about her latest fad. In reply, Meera glorified the pyramid, its powers and how she bathes in the cosmic rays every day. Then one of her smart friends said, "Meera, if you had not wasted time and money in constructing this monstrosity in your beautiful garden, you would not be so keen on selling us this stupid idea."

Comments

Meera is an example of innovative path breakers who avidly and often uncritically accept anything new and novel. They also try to propagate and popularise these into fashion statements. It is in fact quite easy for the gullible to imagine 'the Emperor's new clothes'. It calls for a critical, unbiased and bold mind to see the stark truth and spell it out. I wish there were more like Meera's sceptical friend in our society. Healthy scepticism helps prevent silly superstitions and crazy ideas from turning

into prevalent fashion in the society. However, the way our society handled the "milk drinking God" and the "herbal petrol" episodes in the recent past indicates the relative ease of stimulating our collective gullibility.

Globally, the health professionals too, like lemmings, repeatedly fall prey to the follow-the-leader syndrome. Episodically they push certain disease-labels and treatments because everyone else is doing the same, and it would be unfashionable not to do so. Dr Buram (1987) listed some examples:

1. Treatments of fashion. The use of a third generation cephalosporin, an expensive and powerful antibiotic for community acquired pneumonia (an unwarranted and irrational practice).

2. Fashions in medical jargon.

Stress has been a perennial favourite under many names:

- in 1930's as "fight or flight" response
- in the 50's as Selye's "alarm reaction"
- in the 70's as "type A personality" of Friedman
- in the 80's as "Hot reactor" of Eliot

3. Disease of Fashion. Chronic fatigue syndrome that was known by many other names earlier.

4. Fashions in Surgery. Tonsillectomy, stomach-freeze for peptic ulcer, and gastric balloon inflation for obesity are some humbling examples of fashions of the past. Bernard Shaw (1906) had this to say on surgical fashion: "There is a fashion in operations as there is in sleeves and skirts: the triumph of some surgeon, who has at last found out how to make an once

desperate operation fairly safe, is usually followed by a rage for that operation not only among the doctors but actually among the patients."

The silent sufferer

There is yet another group of persons who also help to propagate myths and fashions. They are the silent-sufferers who follow a silly advice and get conned; unlike Meera, they keep quiet about it so that others would not tease them. Thousands get cheated this way before the whistle is blown by a bold person or a group of persons (see bust-developer - campaign in ch. 26).

The current craze for and uncritical acceptance of all complementary and alternate medical practices is an example of a fashion born of collective gullibility of the society. It is similar to the scenario of 1930's in the West that prompted Shaw to say "The condition of the medical profession is so scandalous that unregistered medical practitioners obtain higher fees and are more popular with educated patients than registered ones."

One day, wisdom will dawn upon us and we too shall realise that most of these fashions have been merely illusory, like the 'emperor's new clothes'.

10. Credibility in health care

The Shepherd's Boy and the Wolf: *A shepherd boy used to derive great fun by fooling the people in the village. Often he used to pretend that a wolf was attacking his flock of sheep and shout loudly,"Wolf! Wolf! Please help!". When the villagers in the vicinity*

came to his rescue, he used to laugh at them. Over time, most villagers were aware of his pranks. Once a wolf really appeared on the scene and when the boy cried for help, no one took notice. The wolf had its own way and devoured the sheep at its leisure.

A) Provider's credibility

Acme Ultrasound Lab. became notorious for over diagnosing gall stones. Based on the report from this Lab., many surgeons initially 'burnt their fingers' by operating on normal gall bladders. Later they became more circumspect about reports from Acme lab. One day, a technician of the Lab. was seized with acute abdominal pain. His scan, done in the same Lab., apparently showed a gall stone. He was referred to a surgical unit. "Report from Acme Lab? Forget it," said the surgeon and ordered a repeat scan at a centre with more credibility.

Comments

To gain acceptability, it is very important for diagnostic services to establish credibility. Credibility is earned by providing high quality and reliable service over a long period. Some health care facilities try to purchase credibility by offering kickbacks and commissions. This may bring short term gains but will prove to be a poor long term strategy if the services are unreliable as "one cannot fool all the people all the time".

It is also true that in order to collect the kickback, unscrupulous care providers may use the credibility factor as an excuse to misguide care seekers to undergo additional tests at unethical health care services that indulge in 'cut-practice', i.e. giving a part of the fee collected as a cut to the referrer (see ch. 18).

B) Seeker's credibility

Raju, a 25-year old unemployed youth, was brought to the casualty with acute severe abdominal pain. The attending surgeon found four surgical scars on his abdomen. He told Raju, "Your history sounds just like acute abdomen but you have already been operated four times earlier. I think you may be a case of Munchausen syndrome and need psychiatric help."

Comments

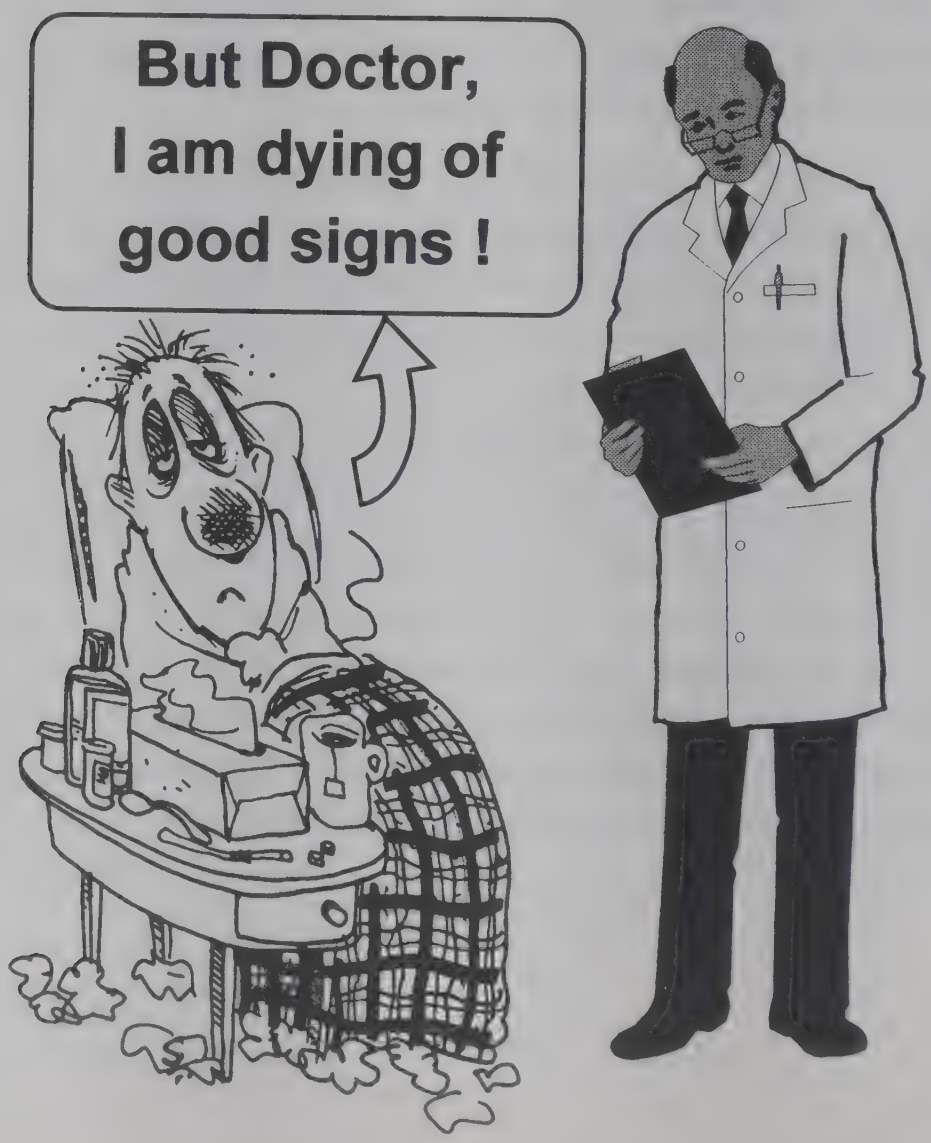
A health care seeker (a patient) is in fact not a mere consumer but a co-provider, a provider of important historical information about the illness. It has been estimated that in a primary care setting, as much as 86% of diagnostic information comes from the history of illness. Physical examination and laboratory tests provide only 6% and 8% of information respectively (Hampton 1975). So it is quite easy for anyone to bluff his/her way into any hospital.

The ideas that a health care seeker is a co-provider and a partner in health care delivery have to be understood by health activists and public. The health professionals should endorse these views by cultivating the habit of talking *with* the patients instead of merely talking *to* them.

Munchausen's syndrome refers to a compulsive attention seeker who goes around with imagined illness and basks in the attention of health care providers. Raju is an extreme case who has fooled the surgeons into operating on him. *Note: There are also some genuine medical conditions that present like a surgical abdomen leading to negative surgical explorations. These cases may be falsely labelled as Munchausen's syndrome and put under psychiatric care.*

11. Seeing through smoothing

The Sick Man and his Doctor: *A sick man was visited by his doctor. "How are you, today?" asked the doctor. "Slightly better but I sweat a lot" replied the sick man. "That is a good sign. You will improve," said the doctor. Next day, the doctor asked the same question and the sick man replied, "I have repeated chills and rigours." The doctor patted him and said, "That is a good sign." The next day when the doctor made a visit, the patient told him, "I feel hot and feverish." The doctor reassured him, "Oh, it is a very good sign of recovery," and left. On the next day, to the doctor's usual query, the sick man replied in a dejected voice, "Doctor! I am dying of good signs."*



Comments

This fable rings true even today! Such mindless smooth talk does anything but reassure. Some reasons why many physicians smooth talk are: wrong modelling, lack of empathy, mistaken notion that smooth talking is the best way of reassuring patients and plain carelessness. You may not mind smooth talks but you should watch out for a careless doctor.

The following are some warning signs that suggest that your doctor may not be doing his/her best to help you.

The doctor -

- does not listen to what you are saying.
- does not probe into your symptoms and complaints.
- does not examine you completely or forgets to examine the organ or body system about which you have raised some doubts.
- seems to be forgetful and peculiar in behaviour, either smiles inappropriately or is short-tempered.
- acts in an unduly paternalistic (fatherly) manner; is all-knowing and tells you "the only way" to manage your problem.
- does not educate you on the nature of illness and the rationale of tests ordered and treatment to be advised.
- does not discuss risks and benefits of the tests, procedures and medicines advised.
- gets upset or reacts defensively when you suggest seeking a second opinion.

It is better to change to a more helpful doctor or at least take a second opinion for major illnesses. "Because modern medicine is so potent, such a two-edged sword, it is necessary

to make careful choices. There is no place for blind faith. You should trust your doctor but only when you are satisfied that the trust is deserved" (Fulder S, 1991).

12. Whose perspective?

> ***The Man and the Lion:*** *A man and a lion were travelling together. They started comparing their superiority, prowess, skills and courage. Presently, they came across a statue of a man subduing a lion. "Look at this," said the main pointing to the statue, "the man is indeed stronger than the lion." "That is because a man has sculpted this statue," said the lion, "If a lion could sculpt statues, I am sure you would see the man underneath and the lion on top."*

Ram and Ralph were friends from their school days. Ralph got into an MBBS course and became a physician while Ram graduated in an alternate system of medicine. Once they got into an argument about their systems of medicine. Each highlighted the greatness of his system of medicine. To clinch the argument in his favour, Ram showed him a big advertisement gloating about his system. "Not so fast, Ram," said Ralph, "That is your view point from your perspective. If we could also advertise like you, I am sure we would be shown to be the best."

Comments

The World Health Organisation has said that all systems of health care have their place in modern day practice. A parallel may be drawn from various modes of travel. There is a need for travel by a jet, a car, a bicycle or even by walk depending on the distance, time and expenses involved. Just because walking

is an ancient and slow method, it can't be ruled out as a mode of travel in the modern times. Similarly, traditional home remedies still have a place to take care of minor self-limiting illnesses like common cold, viral fever, tension headache, etc.

At the same time, it is essential that the limitations and weaknesses of each system are documented and known to the community. This calls for healthy scepticism, unbiased research and reappraisal of various remedies. Media should report these findings in a balanced manner and not yield to glorification, panic-mongering or debunking just for the sake of sensationalism.

As enlightened consumers, one should be critical of generalisations based on anecdotes. Anecdotes say what can happen, not what generally happens. An anecdote may make a good advertising copy but is not a scientific proof.

I have a collection of "faithful fans" who have gone on record stating things like "A touch by your stethoscope keeps me healthy for six months", "If I consult you, all my self-doubt vanishes," and even the ultimate cliche a doctor likes to hear, "You are a God in human form"! I am sure every allopathic doctor has his/her collection of such "old faithful" patient fans. Can we publicise their statements to boost the our own image and that of allopathy? Medical Council prohibits such unethical acts. It should apply to equally to all the systems of health care.

On empiricism, Shaw has said, "Empirics say 'I know' instead of 'I am learning' and pray for credulity and inertia as wise men pray for scepticism and activity. Science becomes dangerous only when it imagines that it has reached its goal." Any science with closed doors becomes a dogma.

Science is verifiable truth. Scientific medicine is rational medicine. The rest are empirical, unproven or faith-based. It is time rationalists and health activists insisted on scientific scrutiny of all systems of health care to identify their strengths and weaknesses. An unbiased, evidence-based consumer guide to the rational use of different systems of health care will be a boon to the society.

In view of the current craze for uncritical acceptance of ancient empiricism, such a consumers' health care guide is urgently needed.

13. Perform as you promise; promise as you can perform

The Impostor: *A sick man felt very ill and thought he might die. He prayed to God for a quick return to health and made a vow to sacrifice one hundred oxen if he recovered. Soon afterwards, he showed signs of rapid recovery but he could not afford to keep up his promise. He made one hundred little oxen out of tallow and offered them to God saying, "God, please accept my offering of one hundred oxen."*

Masani, a self-trained herbalist, claimed to have possession of ancient scriptures that described AIDS and various herbs that cured the disease. Much media hype followed. Thousands of patients consumed the concoction prepared by him. When it did not cure AIDS as he had promised, he said, "All the cases put on weight after taking my drug. That is a sure sign of a temporary cure."

Comments

"Three kinds of medical practitioners are found in this world; firstly, *the impostor in physician's robes;* secondly, *the vain glorious pretenders* and thirdly, *those endowed with the true virtue of the healer*" says Charaka Samhita.

The two undeserving types of physicians also thrive because of the way in which hope and self delusion influence the care seekers. "The capacity of human beings for self-delusion should never be underestimated. Conviction profoundly affects observation. If you think you are right and can convince the patient that you are right, then whether you are right or not makes very little difference." (R. Asher, 1972).

Asher has also commented on hope prevailing over reason. "It is better to believe in therapeutic nonsense than openly admit therapeutic bankruptcy." Colton agreed with him saying, "It is better to have recourse to a quack if he can cure our disorder although he cannot explain it than to a physician if he can explain our disease but cannot cure it."

When some one is ill, there is pressure to "do something" and it may be tempting to try unproven remedies. Health care quackery is big business even in the developed countries. Unethical advertising, uncritical media hype and human gullibility help to propagate it. When the truth about "the miraculous cure" becomes apparent, the stake holder shifts the stance to protect the health care business interests.

In the case of AIDS, modern medicine made the fatal error of admitting therapeutic bankruptcy during the 80's. Media promptly played it up. This lead to mushrooming of quacks and charlatans in USA and Mexico who made wild claims of curing AIDS only to make quick money and vanish. D. Lapierre has poignantly chronicled it in "Beyond Love." Similar quackery is going on in India to exploit the HIV positive cases. This is another area that needs urgent intervention by health and consumer activists to prevent exploitation of the gullible.

14. Quackery

The Quack Frog: *Once a frog came out of the marshy land and croaked aloud, "I am an erudite physician. I have a divine gift. I possess many unique remedies. I can cure any type of disease that you have." Many gullible animals succumbed to the sales-talk. But a fox with his critical faculty intact challenged the frog,*

"You, a healer! You can't even cure your own weak legs and wrinkled skin."

Nath was a glib tongued villager who used to "cure" all sorts of ailments. You can't fool all the people all the time and soon the villagers ceased to seek his advice. He decided to try his luck in the city. He ran an advertising blitz in the health magazines and gave interviews. A smart media person asked him, "If your system is as great as you claim, how is it that no villager consults you?"

Comments

Like politics, *health care has also become the last refuge for many scoundrels*. Quacks like Nath, make hay while the society is ready to 'consume' with a great enthusiasm, any old dogma that is unearthed. Bernard Shaw had a lot to say on this:

> "The condition of the medical profession is so scandalous that unregistered medical practitioners obtain higher fees and are more popular with educated patients than registered ones. In short, private medical practice is governed not by science but by supply and demand; and however scientific a treatment may be, it cannot hold its place in the market if there is no demand for it; nor can grossest quackery be kept off the market if there is a demand for it."

These words of 1933 remarkably reflect the current Indian scene. We continue to be a gullible and uncritical lot.

A cynic may well say, "We crave for and therefore deserve all the quackery that is being unleashed upon us." The activists should take a more proactive role in educating the gullible.

Suspecting Quackery or Fraud in health care

Young JH, a professor of history, has compiled the following points as sign-posts of probable quackery and fraud in health care.

- Exploitation of fear and phobias.
- Claims of miraculous scientific breakthroughs.
- Promise of painless safe treatment with excellent chances of "cure."
- Reliance on anecdotes and testimonials. They don't separate facts from mere opinions and causal effect from a mere coincidence.
- Heavy promotional advertising.
- Large sums of money payable by clients for achieving a cure.
- The use of 'simpleton science' (dogma) like 'diseases have one basic cause' and 'one way of treatment takes care of all diseases'. For example, *water-imbalance is the basis of all diseases and hydrotherapy cures them.*
- The 'victim of scientific establishment' story-line: "The establishment is blind, I am far ahead of times and will be a hero to future generations."
- Shifting theory to adjust to changing circumstances.
- Distortion of "freedom of informed choice" as "freedom of choice" to coax the gullible to end with "freedom to be foolish."

How do quacks succeed?

To find out the secret of their success, one should appreciate the two factors that greatly help them.

- Over 90% of illness are self limiting and the body heals by itself. Even 90% of all the snake bites are nonpoisonous and a quack can claim credit for its "cure" if he is smart enough to detect the minority with venomous bites and refer them to a hospital.
- Of the various factors that contribute to healing of illnesses in a community, only 20% could be ascribed to rational treatment using medicines or surgery. The remaining 80% is divided among three faith based factors. (White KL, 1988)

  i) faith in a placebo (an inactive substance or a procedural ritual).
  ii) faith in a system, a facility or a professional (Hawthorne effect).
  iii) faith in oneself or in the supernatural (spiritual factor or factor-X).

If a quack learns to operate within these three faith-related areas, stay away from any rational therapy that may have harmful side effects and refer the serious cases to qualified physicians, he can be quite successful with a majority of his clients. Faith in a practitioner can be facilitated if the *three arts of medicine*, viz., the arts of Dialogue, Prediction and Remedy are well demonstrated by him/her. The *art* of remedy can even eclipse the *science* of remedy for a long time and a successful quack knows it (see ch. 22).

On the other hand, modern medical professionals tend to confine to the 20% rational (evidence-based) healing and ignore the faith related healing especially in ambulatory care and in managing chronic diseases. They need to be trained to include the placebo, Hawthorne and X-factors in their treatment

options and not reject them as unwanted and unscientific trivia. The disenchantment with the doctors of modern medicine may be largely related to this deficiency in their training. Martin Fischer advised the doctors, "Don't cry out against the quack; find out wherein his success lies and *be a better quack*".

How to bring the faith based healing processes into the fold of scientific practice of modern medicine without usurping its rational base is a challenge for the medical educators and professional bodies.

15. Wrong practice at the wrong time

> ***The Crab and the Fox:*** *A crab once migrated from the seashore to a meadow that was green and full of life. It seemed a good place to feed. One day, a hungry fox came along the meadow and caught hold of the crab. The dejected and dying crab thought, "This is what I deserve for leaving my natural home by the sea and living here as though I belong to the land."*

A doctor trained in homeopathy slowly and steadily started using treatment options from other systems of medicine. He did quite well too, if one considers economic success as the bench mark of doing well. The arrival of Consumer Protection Act did not change his practice.

One day, a patient died of adverse reaction to a powerful allopathic drug prescribed by him. The court passed strictures against "cross-practice" and awarded damages to the patient, as the doctor had "no business to behave as though he was a qualified allopath."

Comments

Cross-practice could be of two types:

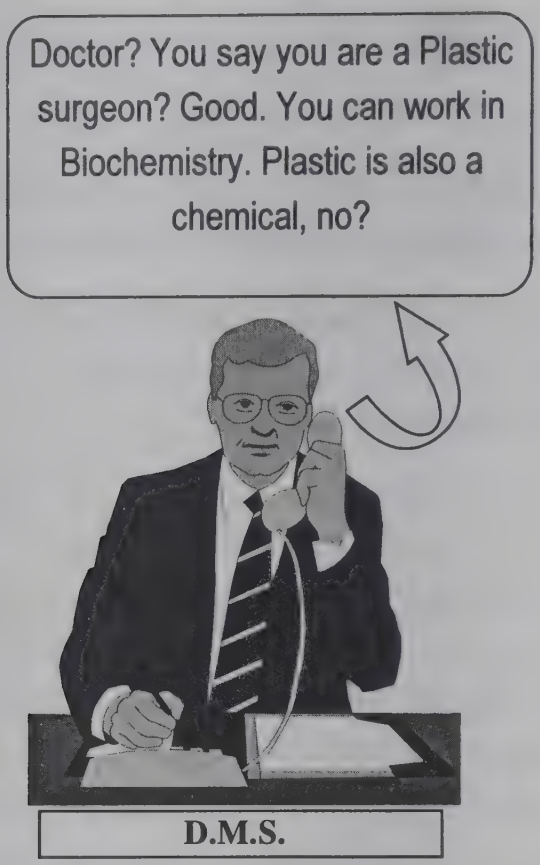
a) across systems, for example, an ayurvedic physician prescribing a homeopathic remedy;

b) within a system but across specialities, for example, a surgeon practising gynaecology or a physician practising paediatrics.

Compared to other professionals, *fidelity to one's own training seems to be rather poor among the health professionals*. A civil engineer does not do electrical installations. A hardware professional does not do software designing. But cross-practice in health care is rampant in India in the private sector. More shocking and less known is the cross speciality practice in the public sector hospitals and medical colleges.

The cross-practice in the private sector was so common that medical practice was in a state of anarchy until the Supreme Court declared in 1996 that the practice of health care should be limited to the area of training, that any violation amounted to quackery and that it was *per se* illegal. The way our professional regulatory bodies and councils ignored the problem until the Law intervened says a lot about their effectiveness as watchdogs of our society (see ch. 18).

The insensitive administration of the government health services create the problem of enforced cross-practice among those in the public sector. A qualified surgeon may be posted in the bacteriology section because there is a vacancy in that department! Many qualified specialists are similarly wasted. Perhaps a court order will be required to set right this malady also.



Some one should file public interest litigation and bring about some logic and order in the postings of health professionals in the government hospitals. *Any takers?*

16. It is your company that counts

The Farmer and the Stork: *A farmer set traps in his corn field to catch the cranes that ate up the corn seeds. When he returned in the evening, he found a stork among several cranes that were trapped. The stork said, "I do not eat corn seeds. I am a stork, not a crane. Please set me free." The farmer replied, "I do not care who or what you are. These cranes ruin my crops. You are in their company. So you shall also be punished like them."*

A specialist centre doing plenty of transplants got notoriety for exploitative and unethical handling of donors. Dr Rahman was the first assistant of the surgical team. He was disturbed by the bad media reports about his centre but kept his concern and feelings to himself.

Once, a Police Commissioner set a trap and exposed the 'transplant scam'. The whole team involved in the procedure including Dr Rahman was arrested. Dr Rahman said, "I only assisted in the surgical procedures. I had no other role." The Commissioner replied, "I have to put you all in. You have been a part of the team. Let the court decide on the individual responsibilities," and took him away with the others.

Comments

Assume that you are a part of a team that may be indulging in unethical acts. It is easy to disown personal responsibility if you are not doing the abominable parts of the activity like misguiding an organ donor or exploiting the recipient. You may well think, "I am only assisting in a life saving surgical procedure. I am not involved in anything else." While this rationalisation may be true to some extent, you may be charged with vicarious responsibility or with abetment of nefarious acts.

Does it mean that you should play the role of a conscientious objector and blow the whistle? Your employer may prefer to label you as a rat, a mole or a traitor and make your life miserable. I had a first hand experience of this as a junior consultant in a cardiology unit. The head of the unit used to admit persons with a normal heart for some experiments on them that involved cardiac catheterisation (the passage of a small tube into different chambers of the heart) and giving them stiff doses of some drugs. Whenever I was the admitting

doctor, I used to inform them of the procedures involved and naturally all but those who desperately needed a medical certificate of health, refused to get admitted. Soon, I was labelled as a person fit only to be in a primary health centre and was advised to quit. I did not quit but blew the whistle and spilt the beans to the administration. Since they wanted no bad publicity by such unethical experiments, the unit-head was asked to leave the centre. The whole episode left a bad taste and I quit working in a tertiary care set up.

Long term studies in USA have revealed that whistle-blowing resulted in economic bankruptcy, emotional deprivation, disruption of career and family life and personal abuse (Soeken K, 1987). The whistle blowing stems from the moral motive of preventing unnecessary harm to others. (Bowie N, 1982) But the motive is often accompanied by a 3-way conflict: The professional ethic requiring collegial loyalty clashes with responsibility to the public. The third element is the fear of retaliation (Callahan D, 1980).

This conflict has been classically dealt with in the great epic, Ramayana. Vibhishana, the brother of Ravana, overcomes the loyalty-trap and crosses over to Rama's side. Kumbhakarna, on the other hand, chooses the path of loyalty rather than morality and prefers to die in the battle that ensues. The former was wise and the latter, brave. We are left to choose our own path dictated by our personal values and morality.

17. Fighting over a case

The Lion, the Bear, and the Fox: *A lion and a bear were fighting with each other for the right to devour a little lamb seized by them at the same time. The fight*

was long and fierce. At the end of it both lay wounded and exhausted. A fox which was watching the scene for long realised that they were too weak to even stand up. He moved in and ran off with the lamb.

(a) Case grabbing: Seeta, a 30 year old school teacher, consulted a corporate hospital for a neck swelling. An Ear, Nose, Throat specialist diagnosed it to be a thyroid swelling and told her, "It needs to be removed. I can do it. There is no great hurry. Take your time to arrange for your medical leave, etc., and come back within a month or two."

Seeta was apprehensive about an operation and consulted a general surgeon for a second opinion. He examined her and said, "Yes. It is better to operate and remove it without any delay. I can do it next week." When she informed him about the earlier consultation, he rang up the ENT specialist and they started arguing who should operate on thyroid glands.

Seeta was stunned at this development and left the hospital. She was taken to a plastic surgeon by a health care worker. He managed to convince her that the operation-scar was the most important thing about neck surgery and operated on her.

(b) Case dumping: Beevi, a 50-year old farm labourer, went to a large teaching hospital as she had not passed urine for three days. The duty physician found that the kidneys were distended with urine and referred her to a urologist. The urologist confirmed an obstruction to the urine flow and wanted a gynaecologist to look for pelvic cancer. Pelvic examination revealed cancer of the neck of the womb (cervical cancer). On the question of admitting the case, there was disagreement among them.

The Gynaecologist said, "She has uraemia. It is not our problem now."

The Urologist said, "She has high urea level. It is not our problem now. Lower the urea first."

The Physician said, "How can it be our problem? Unless the obstruction is relieved, the urea will keep mounting."

Beevi was vexed by all this delay and by the way she was prodded and pushed around by the doctors. "Let me go home and die in peace," she thought and left the hospital. The doctors detected her absence much later and recorded on her case file, "case absconded."

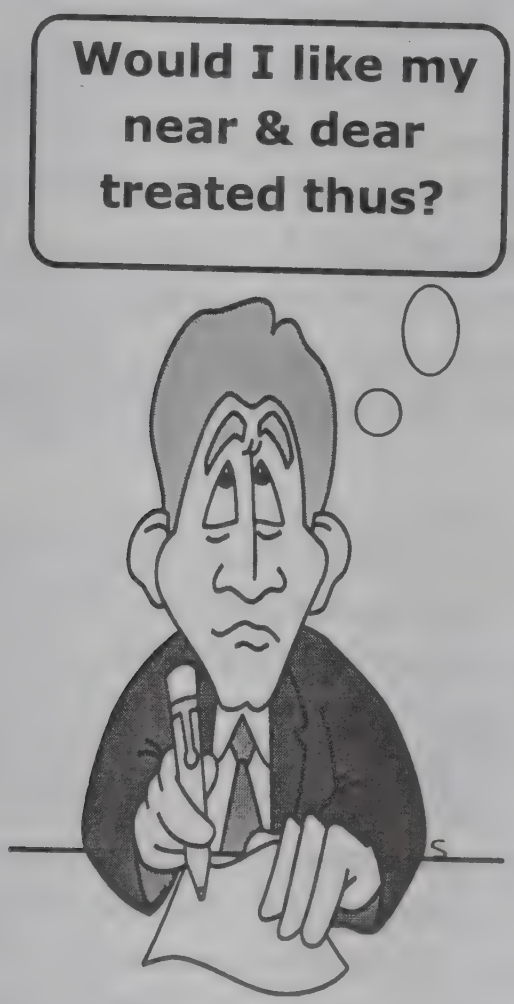
Comments

Case-grabbing is a big business now. Health care workers, taxi drivers and others are being employed as touts to fetch cases for surgery and other procedures. These touts can be spotted in and around hospitals offering unsolicited helpful advice to prospective clients. My students, who work in the private sector say, "Cases admitted for surgery are discharged 'against medical advice', transferred to another hospital at night and operated before the daybreak. Disloyal employees are involved in this racket and get a good commission for every case transferred."

If case-grabbing is rampant in private sector hospitals, case-dumping is equally rampant in the public sector hospitals. In USA, over 250,000 emergencies were shifted in a year from 'for profit' hospitals to public hospitals because they could not pay. About one in ten, i.e. 25,000 cases died, mostly due to delay in transit. (Sibbison JB, 1991)

In India, the situation of patient dumping is far worse. Just talk to any patient with a low income and he/she will speak volumes on this. We need effective regulations to curb this practice in public hospitals. The recent release of Citizens Charter of Health Care Rights in Government hospitals is a step in the right direction (see appendix).

A conscientious doctor, who wants to know if a proposed action is ethical, can apply the following self test: "*Would I like myself or my near and dear to be treated thus?*" If the answer is 'no', then the proposed act is unethical.



18. Why a 'cut' for what you can't do

The Wolf and the Horse: *A wandering wolf walked through a field of well-grown oats. Since wolves do not eat oats, he gave it no further thought until he came across a majestic looking horse. The wolf, wanting to ingratiate itself with the horse, said, "Look, my friend, here is a field of fine oats. I knew you would like to eat them. I haven't touched even a single grain. Let me have the pleasure of watching you munch it all." But the horse was unmoved and said, "If you wolves could eat oats, my friend, you would have hardly indulged in comraderie at the expense of your belly."*

Dr Abu was a physician with a busy practice in a polyclinic. Dr Babu joined there as a surgical consultant. "Welcome aboard" said Abu, "My ward has plenty of cases who need surgery. I have kept them just for you. I would like to see your fine work on my cases." Dr Babu grinned wryly and thought to himself, "If only you could operate, my friend, you would not have kept your cases waiting just to see my fine work."

Comments

Absence of such "horse sense" makes a referee feel obliged to the referer, and leads to the practice of kickbacks and 'cut-practice'. Unlike the consumer market, where competition reduces prices, in health care, the cost to a consumer goes up. This anomaly occurs because consumers have no direct access to health care services; they have to go through a health care provider. When competition gets hot, the industry offers more inducements to the care providers to entice them to refer more clients. The enhanced inducement costs are ultimately paid by the clients without being aware of it. Ten to sixty percent of the

collected charges are paid by diagnostic centres and referral hospitals to the referring doctors (and other providers) as 'cuts'.

The practice of collection of fees and splitting it with the referring doctor has become commonplace. It is euphemistically called as 'professional fee', 'follow-up fee', 'professional service charges, ' etc. The rationale offered is that the referring doctor has to 'correlate the laboratory data with the clinical picture' and 'follow up the case after the specialised treatment'.

However, the real picture is scandalous. The provider-seeker relationship, based upon trust and fiduciary norms, gets corrupted by this vicious process. Just look at the facts:

- The patient has already paid and will continue to pay the referring doctor.
- The fee splitting is concealed from the client.
- The 'cut' for the referrer is an incentive to refer more cases for specialist service.
- It abets and entices a doctor to forget the fiduciary nature of provider-seeker relationship.
- The professional is reduced to being a prescribing robotic arm of the health care industry; the doctor's role is vulgarised to being a vendor-solicitor rather than a trustworthy friend, philosopher and guide (see ch. 2).

Do you feel I am exaggerating? Just read the following extract from the Journal of Medical Ethics:

> "I saw a friend of mine, a consultant, earning a hundred rupees from a patient. He gave sixty rupees to the family doctor who brought the patient. My friend subjected the patient to a host of tests that were not

needed and removed his healthy appendix. Twenty-six years of honesty, integrity and self-respect were washed down the drain in just a day. He has joined the rat race to earn a living" (Muralidhar V, 1993).

In the same journal, Dr MK Mani, the famous nephrologist of India, has published his correspondence with the Medical Council of India (MCI). The MCI is the watchdog body that regulates allopathic medical practice in India. Dr Mani had sent them proof of fee splitting, in this case a sum of Rs 2,000/-, for referring a patient with renal stones for ultrasonic treatment. He had implored the referee to stop offering such incentives and to reduce the patient's charges instead of "bribing the doctors to send more patients." Many letters were exchanged with the MCI but to no avail. As the title of his article says, *'Our watch-dog sleeps, and will not be awakened'*. (Mani MK, 1996)

Recently, in mid '99, there was a laudable attempt at Chennai to curb the practice of giving commission for referrals. Unfortunately, greed prevailed and the facilities who actually stopped paying commission lost clientele and had to resume the nefarious practice to fall in line with the others and survive.

Bernard Shaw had cautioned us in 1933 when he wrote, "Until the Medical Council is composed of hard working representatives of suffering public, with doctors who live by private practice rigidly excluded except as assessors, *we shall be decimated by the vested interest of the private side of the profession in disease*." These are no doubt strong words but none the less, entirely applicable to the current Indian scene.

Will the profession ever get the 'horse sense' to follow an ethical path? When?

Does the public realise that up to 60% of the health care cost is spent on kickbacks and bribes to solicit more health care business? Does it care? How can these concerns be converted to effective actions?

Meanwhile, a conscientious professional can use the following self test: "*Would I like the arrangements between myself and the referee known to my patient?*" If the answer is 'No', then the arrangement is unethical and is to be abhorred.

I know some ethical physicians who give the 'professional fee' back to their patients, saying that they were eligible for a special discount. There are others who use the 'Robin Hood principle' and get free service for the poor in lieu of the kickback.

Until we get truly emancipated from the curse of cut-practice, our society needs more of such unsung heroes.

19. Accountability

> ***The Bee-keeper:*** *A thief once stole all the honey from beehives when the bee-keeper was away. The bee-keeper was upset when he returned to find empty hives. Soon the bees also returned and gave vent to their feelings by stinging the bee-keeper. He cried, "You ungrateful bees! You let the thief go scot-free and then show your anger on me for taking such good care of the beehives till now."*

Kumar, a 10-year old boy, developed fever, headache and vomiting. A local quack prescribed him 'fever set', a concoction of many medicines. Initially he responded well but the symptoms returned on the fourth day. The quack then told his

parents to take him to a hospital. At the hospital, no definite clinical signs were found except mild fever. He was sent home as a case of 'viral fever?' and asked to stop all the drugs and watch.

Kumar worsened dramatically over the next 24 hours and was again taken to the hospital for review. By then, signs of advanced acute meningitis (acute infection of the membranes covering the brain) had developed. Despite intensive treatment, he died three days later. The angry parents accused the hospital of negligence and sued them for damages.

Comments

In acute illnesses, proper initial management is the most important step. If wrongly done, it can miss, mask or modify the disease. Quacks (and incompetent physicians) practice polypharmacy, ie, using many medicines so that at least one of them might 'cure' the illness or control the symptoms. This is like *firing a shot gun hoping that at least one pellet may hit the mark*. Such shot-gun-treatment may seem to work in about 90% of cases. These are generally self-limiting illnesses that disappear in three to seven days (see ch. 14).

Unfortunately the shot gun approach masks or modifies the clinical picture of a serious illness in the remaining cases. By the time the quack recognises that all is not well and refers the case, the symptoms and signs may be distorted. A qualified professional who examines such cases may be unable to diagnose them. I often admit such nondescript "handled-outside" cases for observation. It may take up to a week for the clinical signs to reappear.

It is not only quacks but even many aim for 'quick-fix solutions' and create such partially treated problem cases by

mindless and irrational shot gun therapy. When matters worsen to a crisis, they palm-off these 'hot potatoes' to other specialists, usually a government hospital. The next professional who handles such a case may burn his/her fingers and face the wrath of the relatives of the patient.

How can you help reduce this problem?

- As an enlightened health seeker, you should see qualified health care providers.
- Avoid self-medication, especially for any new symptom or of a new drug you have never had before.
- You should get the case details and prescriptions in writing and preserve them.
- If you buy medicines from a medical shop, collect the bill and preserve it.
- Show all these documents to other health care providers when you happen to consult them. A health care diary helps a lot especially in the follow-up of chronic or recurrent health problems.

How should a health professional manage such a situation?

Most patients are reluctant to talk about any earlier treatment for fear of scorn, rebuke or rejection. First, elicit the truth about any earlier treatment by coaxing and non-judgemental listening. Then examine carefully for any soft signs of a serious disease process. If they are found or even suspected, it is safer to keep them under observation. Even if they are sent home, it is better to explain to the patients that the signs may be masked for a day or two and encourage them to consult you again if he/she feels worse later. In short, be proactive than reactive.

Accountability in health care is a burning issue now. The care seekers and providers have to understand clearly the various types of 'perceived accountability'.

Accountability - an insider's perspective

I have had an insider's view of the medical audit since 1972. The accountability in health care is much more complex than the simplistic view often expressed by consumer activists and in the media. I have classified real and perceived medical mishaps under three categories (see the box).

1. Errors of Commission (subtle to gross), e.g., Amputation of normal leg by mistake.
2. Errors of Omission (subtle to gross), e.g., Omitting a vital step during a procedure like anaesthesia.
3. Misunderstanding:
   a) Cause and effect fallacy
   b) Inherent risk in a procedure
   c) Wisdom by hindsight
   d) Misleading clinical picture - "Red Herrings"
   e) Misleading acts by a patient, e.g., wrong history, covert noncompliance, malingering, etc.

A discussion of the types of health care mishaps and the accountability of a provider and of a seeker in these mishaps may broaden the outlook of activists. This is essential for any meaningful and constructive debate between professional lobby and consumer/health activists.

1. Errors of commission

Gross mishaps of this type make media waves. The facts speak for themselves in such unfortunate instances. A consumer court can easily fix the responsibility and quickly award the damages. Most cases of this nature occur due to human errors. They are not deliberate acts of manslaughter. While the surgeon who has amputated the wrong limb must be held accountable, he/she should neither be projected as some monster, as is often done by the media, nor be treated like a criminal by the police.

Human errors do occur and will continue to occur in all spheres of human performance. While the victim deserves all the sympathy and timely redress, the professional who has erred also deserves humane treatment.

I am more perturbed by the covert errors of commission perpetrated by some practitioners of 'hi-tech medicine'. I refer to the ruinously expensive treatment options advised to the middle class care-seekers that leave their family in ruins (see ch. 2 & 3). A true professional is not a mere vendor trying to push products and services. He/She should take the life-world of the client into reckoning before advocating any treatment (see ch. 52). It should be a sustainable option in chronic diseases. Like a Tamil saying goes, "Do not jump halfway across a well."

How to detect and eliminate such overt and covert errors of commission is a challenge to anyone concerned with quality of health care.

2. Errors of Omission

These are technical in nature. Lay persons may not detect them except perhaps feeling that something has gone wrong.

An unbiased medical audit by professionals is the only effective and practical way of addressing these errors (see ch. 51).

3 (a) **Cause and Effect fallacy** is common and avoidable. An example will make it clear: Babu, a 50-year old person reported to the casualty with numbness of the right thumb. The doctor suspected early stroke-in-evolution and administered drugs by an intravenous drip for six hours. By then Babu was paralysed on the right half of his body. He had also lost his speech. Then his relatives shouted at the doctor, "Babu was brought here with just a little numbness. The wrong treatment given here has produced a severe paralysis" and blamed him and the hospital of negligence. Actually, the stroke, which had begun with a numb thumb, had progressed to a 'completed stroke' despite the medication given to counter it.

Such misunderstandings of cause and effect are sickeningly common. It exposes the naivete and paternalism among the medical professionals. They react with righteous indignation and say, "We did our best for the patient and all we got in return was blame and abuses."

A proactive doctor can help avoid such allegations. The doctor who treated Babu knew that it was a "stroke-in-evolution." He also knew that despite all the treatment to try and arrest it, most cases end as "completed stroke." If this had been explained to the patient and his relatives at the time of admission, then the subsequent scenario would have been totally different. The doctor would have been labelled as a 'saviour and God in human form' if Babu had been lucky enough to escape from a complete paralysis. Even when Babu developed the paralysis, his relatives would have known the true state of affairs and not blame the doctor or the treatment given to him.

(b) Inherent risk in a procedure is often glossed over before some mishap occurs. Professionals justify this by saying that "the patients should not be scared away by knowing all the possible risks." But when the risk is realised in a particular case, the person and the family are devastated and may react badly. An example: Ismail, a 2-year old boy died of bleeding after "a simple circumcision." The aggrieved father got the surgeon arrested for 'alleged manslaughter'.

Informed consent for any procedure should include discussion on the benefits (best possible scenario), the risks (worst possible scenario) and the likelihood ratio of a successful outcome. In India, many care-seekers are dependent type and have implicit faith in their doctors. It is all the more important in these instances to inform his/her relatives of the possible outcomes (see ch. 4 for 'questions to ask your doctor before any surgery').

(c) Wisdom by hindsight is often witnessed during a medical audit. The initial clinical picture is incomplete in most cases. The treatment options are many. Decision making is complex and is often guided by hunch, insight, gut feeling and experiences. Clinical practice is the art of successfully managing uncertain problems and unpredictable situations. If the outcome is acceptable, no questions are raised. Otherwise, a retrospective analysis may suggest that if the clinical decisions had been different, the outcome might have been better. This type of audit is of much use in learning for the future. It should not become a witch-hunt.

One way of avoiding accusations by such witch-hunts is to document the ambiguities in the clinical picture and why a particular option has been chosen over others. If the patient can

be taken along with conviction, then so much better for the science and art of medical practice.

(d) Misleading clinical picture could be due to 'red herrings'. These are clinical and laboratory findings that confuse or confound the clinical diagnosis. One needs much expertise and experience to ignore these false leads (see ch. 8).

More insidiously misleading is the occurrence of a second disease that has symptoms similar to those of an already existing disease. For example, the headache of a brain tumour occurring in a person with many years of migraine may not get the attention it deserves.

After getting occasionally fooled by second diseases, I have adopted a "zero-based approach" to chronic diseases. In this approach, every patient with a chronic disease like diabetes, migraine or asthma is periodically examined and investigated 'like a fresh case'. All the symptoms and signs are thus reassessed to unravel any hidden superimposed diseases. An observant patient can also help by comparing the present symptoms with that of the past. Any new symptom or a change in the symptoms may herald the onset of a second disease.

(e) Misleading patient behaviour: Some health/consumer activists take the stance that the care seeker has no role, responsibility or accountability in his/her own health care. This is clearly untenable. Providers are not mere vendors but are professionals who need an honest and unbiased input from their patients. Most of the diagnostic yield is obtained from listening to the patient describing the problem. Therefore, any person seeking health care is a 'co-provider' and not a mere consumer. (Personally, I still prefer the term 'doctor' than 'provider' as the former stresses the educator role of a health professional.).

Some other major ways of misleading doctors are by concealing noncompliance to treatment and non-adherence to life style changes; the most problematic is of course one who feigns an illness for various reasons *(see 'Munchausen syndrome' in ch. 10).*

The way ahead

Anger blinds. It distorts the truth. It renders a just solution on the issue of accountability in health care out of reach.

Just as a professional has responsibilities and rights, a patient also has responsibilities and rights. They should be partners in all health care transactions. These transactions must be cooperative and based on mutual trust. The current mis-understanding between the health professionals and the consumer activists must give way to a constructive exchange based on openness and sharing of mutual concerns.

We can find a way out if we bury our anger and mutual distrust and work towards quality health care.

20. Cooperation is strength

Father and Sons: *An elderly man was worried that his sons were always quarrelling with each other. He could not get them to live in harmony. One day, he asked them to meet him with a bundle of sticks. He challenged them to break the tightly tied bundle of sticks. They could not do so. However, when he undid the rope and gave them the sticks one at a time, the sticks could be broken with ease. He advised them to remain united against the enemy. If they quarrelled and fell apart, they would be too weak to succeed in life.*

Comments

Health care providers, care seeking public, the industry (diagnostic, therapeutic and insurance), media, activists and governmental machinery are the six key players in health care delivery system.

Each key player of the system is like a stick. If all of them cooperate and stand together to achieve the goal of *ethical and effective health care for all*, then the system will be strong and functional. If each player sets his own agenda, forgetting the common goal, then the system will be weak and dysfunctional.

Some examples of such deviations are:

- Ignorant, corrupt or unethical health care provider.
- Foolish, noncompliant or deviant behaviour by the care seeker.
- Exploitative health care industry.
- Biased media that glorifies or vilifies a health care issue.
- An activist with a one track mind resulting in a stand off among key players.
- A government that puts profits before people.

The outcome measure is *not profit or high technology but quality care based on provider-seeker trus*t. If the basic trust is undermined, as has happened in USA, the health care system will be in jeopardy and every player will ultimately be a loser. Trust is the glue that keeps the system together. Without that, it will fall apart like Humpty Dumpty and we may not be able to put it together again.

Some of Bernard Shaw's concluding remarks in his preface to 'The doctor's dilemma' are worth noting here:

- Do not try to live for ever. You will not succeed.
- Use your health, even to the point of wearing it out. That is what it is for.
- Decide how many doctors the community needs to keep it well. Do not register more or less than this number
- Of all the antisocial vested interests, the worst is vested interests in ill-health.
- Nothing is more dangerous than a poor doctor.
- Treat the 'private operator' exactly as you would treat a private executioner.
- Treat persons who profess to be able to cure (incurable) diseases as you treat fortune tellers.
- Take utmost care to get well born and well brought up. Otherwise, you will be what most people are now: *an unsound citizen of an unsound nation without sense enough to be ashamed or unhappy about it.* (Shaw 1906)

SECTION - II
CHARACTER IN HEALTH CARE

All knowledge attains its ethical values and its human significance only by the humane sense in which it is employed. *Only a good man* (sic) *can be a good physician.*

Hermann Nothnagel (1841-1905).

21. The situation gives power

The Lion and the Mouse: *A little mouse ran over a lion's face by accident. The lion lost its temper and was about to kill it. Then the mouse begged him to spare his life and said, "If you let me go today, I will repay you for your kindness another day." The idea of such an insignificant creature offering help was so amusing to the lion that he laughed aloud and let it go away. One day, the lion was trapped in a net laid by big game hunters. The lion was unable to break free and roared in anger and frustration. The mouse heard the roar, came there and gnawed away the ropes of the net in a jiffy. The lion realised that even a little mouse could be of great help to others.*

When Murkhi, a slum dweller, got successfaully operated at a municipal hospital by a famous surgeon, he was extremely grateful. "Sir, one day I will repay you for your kindness," he said to the surgeon. This offer amused the surgeon. He laughed affably and discharged Murkhi. Two months later, there were big riots in the city. A mob stopped the surgeon's car and was about to attack it. Murkhi was in the vicinity and recognised the car and its occupant. He ran to the mob, pacified them and saved the day for the great surgeon.

Comments

Health professionals play God and make life and death decisions as a matter of routine. Over time, their ego may inflate so much that they stop looking at their patients as equal human beings. It is at times like riots and calamities that they stand exposed and feel vulnerable.

The Murkhi-episode is a true story and it happened in Mumbai during the post-Ayodhya riots. The surgeon who was saved by Murkhi, later confided in me thus: "It was a near death experience for me. I thought I would be lynched by the mob. When Murkhi got me through the mob safely, I felt he was God in human form. He seemed so omnipotent. Then the realisation struck me: how vulnerable would my patients feel before their surgery and how my routine professional work makes me seem omnipotent in their eyes! I have changed now. I feel humble. *I feel privileged to have the power to help fellow human beings.*"

Clifton gently reminded the doctors, "*You are a patient's advocate - you work for no one else.*" Can the health professionals stop acting like omnipotent Gods and transform themselves to be the privileged advocates of their fellow human beings? Or do they all have to undergo near-death experiences like my friend from Mumbai?

22. Faith is a golden goose

> ***The Goose that Laid Golden Eggs:*** *A couple had the good fortune to possess a remarkable goose that laid a golden egg every day. Though happy initially, they soon got tired of waiting for just one golden egg per day. They decided to cut open the goose and collect all the gold inside the goose. Alas! When they killed the goose and cut it up, it was just like any other goose. They lost even the little gold they used to get earlier.*

Swami Harinath was famous for his herbal remedy for chronic joint diseases. The potion was processed with great care and took 48 days to prepare. Every patient had to keep it

in the prayer room for three days and then consume it. Every dose was accompanied by meditation and chanting of some slokas. The Swami could attend to only a few cases at a time. He had a long waiting list of hopeful patients.

After his demise, his associates decided to speed up things, cater to all the clients and make quick money. The Swami's caution 'not to change anything' was forgotten. They got the potion analysed, mass-produced it and marketed it all over India. The potion failed miserably and soon they were bankrupt.

Comments

Foolishness of the greedy act seems obvious enough but greed, like anger, blinds one to reality. The swami had realised that faith was the most important element that made his remedy a success. Perhaps he also knew that a 'scientific scrutiny' of faith based healing agents is like dissecting the golden goose - nothing will be found!

Faith is a major force in healing, especially in chronic diseases. Dr S. Kakkar has analysed these powerful persuasive healing forces in his scholarly book "Shamans, Mystics and Doctors." Wickenburg consensus has suggested that 80% of healing in ambulatory practice is faith based and only 20% could be ascribed to rational intervention. The faith could be on a Supreme Force, oneself, a health care system, a healer, a physician, a procedure or on a medication (see ch. 14).

How to incorporate these powerful healing forces into the rational and scientific practice of health care is one of the greatest challenges of the present. Clearly, a new paradigm is needed to merge the art and science of medical practice in an ethically acceptable way.

23. Is Honesty the best policy?

Mercury and the Woodman: *While he was cutting a tree on the river bank, a woodman lost his axe when it accidentally fell into a river. He was wondering how he could ever get back his axe when Mercury appeared and offered to help. Mercury dived into the river and came up with a golden axe. The woodman said, "Oh God! Mine is not a Golden axe." Mercury dived again and brought up a silver axe. The woodman shook his head and said, "Sir, mine is an iron axe, not a silver one." On his third dive, Mercury recovered the woodman's axe. The woodman was overjoyed to get his axe back and thanked Mercury profusely. Mercury was so pleased with the honesty of the woodman that he presented him with the other two axes.*

Mr Ram, an industrialist, was indicted in a scam. He was widely expected to be arrested soon. In order to avoid being in the jail, he flew in a top cardiologist to examine him for "severe heart pain". The doctor 'diagnosed' a serious heart ailment and put him in the VIP suite of a 5-star hospital for a month's rest.

Comments

Unfortunately, in real life, dishonesty seems to pay rather well - at least in the short term! A Mercury of today may well say, "I can give the golden axe if you will let me keep the silver one." And a desperate woodman of today may well reply, "I'll let you have the golden axe. Just hand over the silver one."

The ploys of the doctor-patient nexus to fool others are too well known. Just look at the number of false medical certificates, false receipts for medical reimbursements, spurious laboratory reports, false admissions into a hospital to escape

staying in a jail. *A medical certificate has become one of the most discredited documents of this country.*

Dr. Mira Shiva, a well-known health activist of India, has told me about some unfortunate women of Assam who were put in lunatic asylums by false medical certificates. My colleagues in forensic medicine recount instances of falsification of post-mortem reports. The list is endless.

- Can the health professional recover his/her credibility ever again? How?
- How can we make honesty more attractive than dishonesty?
- Can health care alone be an island of purity in the cesspool of Indian public life?

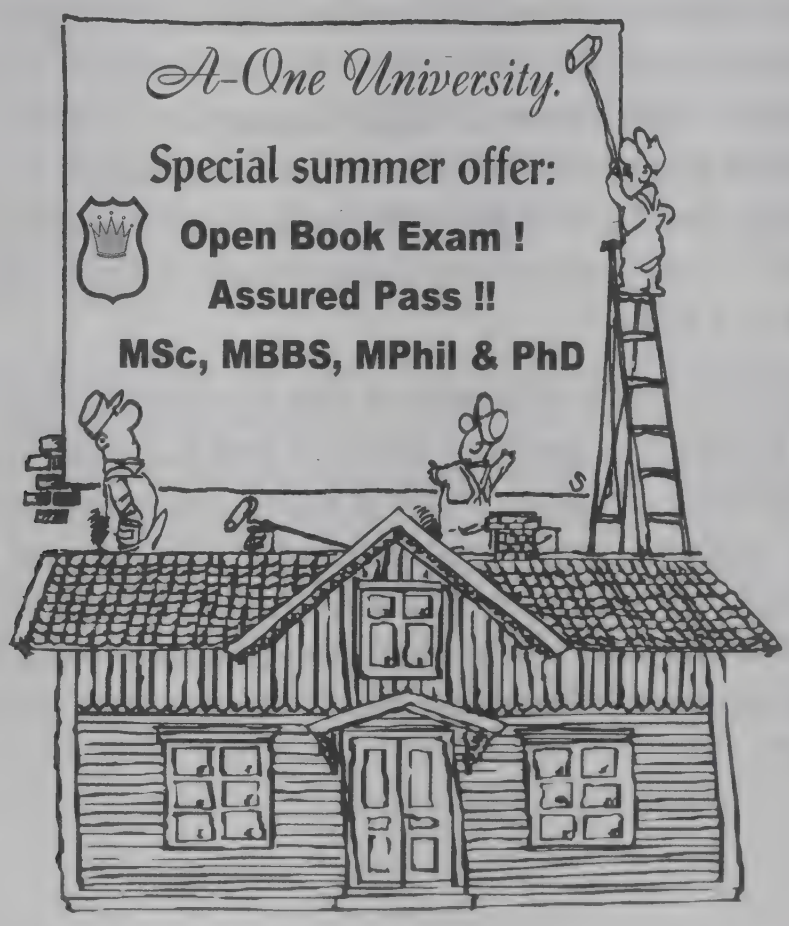
24. Quality or quantity?

> ***The Lioness and the Vixen:*** *A lioness and a vixen were talking about their wonderful offsprings. Each gloated about how well they behaved and how cute they looked. The vixen wanted to score a point over the lioness and said, "My litter of cubs in such a beautiful sight. But I notice that you never have more than one cub." "No," agreed the lioness with a smile, "but my cub is a Lion."*

Two professors of medicine met at a conference. One was from a prestigious national Institute and the other from one of the mushroom colleges. After a while, the conversation dwelt on the students and their training. The second professor exclaimed, "What! Your Institute trains only 60 students per year! We produce 300 graduates every year." "I agree," said the first professor, "but every one of our graduate is *an Institute product*!"

Comments

During every summer, new medical colleges spring up like mushrooms. The promoters rake in huge capitation fees, as much as Rs twenty to thirty lakhs per candidate. The candidates are happy to get a medical seat that they would not have got otherwise. Their parents are relived to get rid of much of the 'black money' and delighted that their children would be doctors. Every year, India produce about 18,000 medical graduates with MBBS degree from about 170 medical colleges. About 7,000 go for higher studies. The rest join the pool of about 5,00,000 allopathic doctors. An equal number of doctors of other systems compete with them. The unhealthy competition leads to distortions in practice. With some notable exceptions, the quality of the practitioners and of medical practice are quite deplorable.



There is another aspect of the number-game in health care. To impress others with the quantum of practice, many practitioners like to keep a long line of waiting patients. Some have patients waiting up to midnight for a consultation. By then, the doctor is so tired and sleepy that some prescriptions are simply hilarious at best or atrocious at worst. A hilarious example: One tablet of a liquid tonic three times daily! A dangerous one: a penicillin-like drug for a penicillin allergic patient.

The ultimate sufferer in this number game is the health care seeker. In most of the over crowded clinics, the quality of care is from mediocre to abysmal. That most care seekers do recover and go home speaks for the resilience of the human body.

A similar number game is also played in medical research. Many researchers rehash the same article up to ten times and quote their own papers repeatedly. Others falsify data and publish them. Only those who overdo it get caught and are exposed. Until researchers are rated by the quality of their work, the 'publish or perish' syndrome will thrive.

The stakeholders must realise that there is always a tradeoff between quality and quantity. We should strive to find the right balance to maintain quality in training, research and patient care. The regulatory and professional bodies should suggest national norms. It is long overdue.

25. Boasting in health care

The Boasting Traveller: *A man once travelled overseas and visited many countries. On his return, he spoke of the wonderful things he had done abroad. "I took part in a jumping competition at Rhodes. I did such a wonderful long jump that no one could beat it."*

When he sensed that some listeners were unconvinced, he said, "You ask any one in Rhodes and he will tell you it is true." A listener retorted, "My dear friend, we need not go to Rhodes to verify if it is true. Let us imagine that this is Rhodes. Now jump and show us your prowess."

Dr Singh, an ophthalmic surgeon trained in Russia, joined a corporate hospital in India. "Revolutionary Laser Surgery for short sight! The most successful Laser Surgeon joins Hygea hospital" said the advertisements. The media sang praises for Dr Singh: "Trained in Russia. Has 100% success rate!", "One of the most successful keratotomy surgeon in the world!", etc. Without verifying the facts, myopics registered in large numbers for the latest surgery. Quite a few of them had adverse effects after the surgery. A few unfortunate ones lost vision in the operated eye. When the truth could no longer be suppressed, the surgeon vanished and the laser centre was closed down.

Comments

The health care industry boasts and promotes itself to attract clients. Some researchers boast about experimental drugs or procedures to gain fame or to get volunteers for their study. The drug industry may boast about their products to coax doctors to use them uncritically. Quite a few of the top 100 drugs sold in India do not find a place in textbooks of drug-therapy. Clever advertising coaxes doctors to prescribe and their unsuspecting patients to buy these irrational remedies. Millions of rupees are thus wasted.

Seeing through a boast is not difficult if you keep the critical faculties active and not get carried away by hype and false hope. The follwing signs should put you on guard:

- Expansive know all posturing,
- Giving personal opinions than facts,
- Talking in absolutes and,
- Statements worthy of a megalomaniac.

Like the odd-disbeliever in the fable, *ask for verifiable proof before accepting any claim.*

In health care, boasting is harmful and expensive. It diverts the attention from rational care. *Ban empty boast.* The Reserve Bank of India has done it in the financial circle. Now all the financial advertisements carry detailed warnings on all the risks involved. We must similarly regulate health care advertising. The Medical Councils can ban boasting in health care. They have a duty to protect people from continuing to fall victims to unscrupulous health care industry. *It is never too late.*

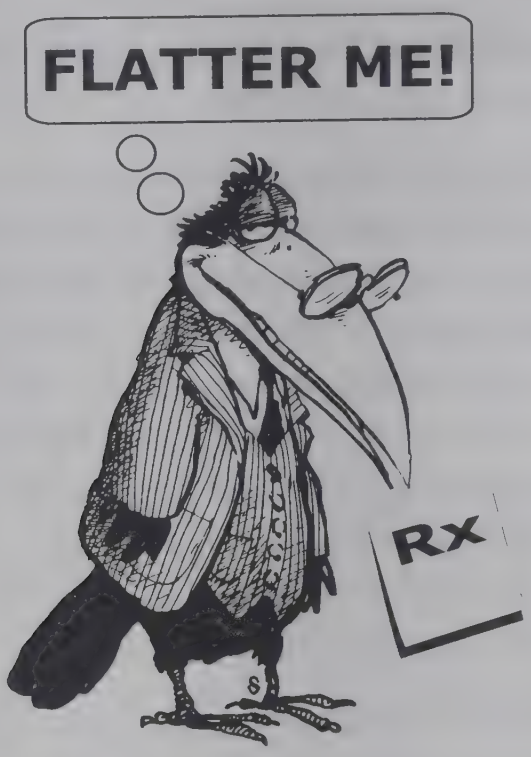
26. Flattery dulls the intellect

The Fox and the Crow: *A fox noticed a crow sitting on a tree holding a piece of cheese in her beak. The fox thought of a plan to get the cheese. He praised the crow's beauty in great detail and flattered her. He told her, "If only your voice is as noteworthy as your looks, you will be the queen of birds." The crow wanted to show the fox that her voice was sweet and opened her beak to caw. The cheese fell down. The fox snatched it and told the crow, "You have some voice. What you need is some brain."*

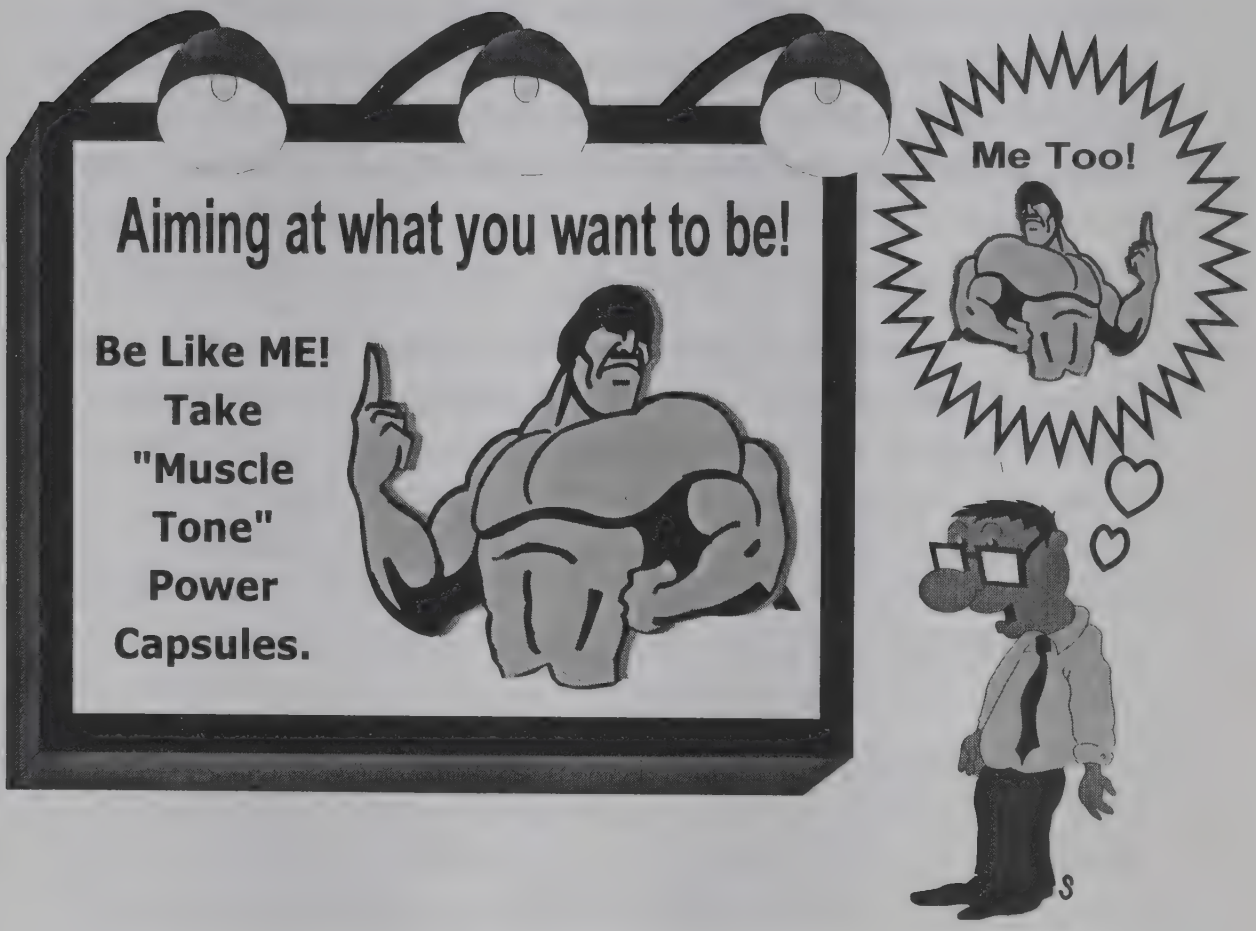
Comments

Advertising is the Fox of today. Advertising aims at the heart to cultivate positive feelings and tries to bypass critical cerebral faculties like logic, scepticism and judgement.

Humorist Stephen Leacock has said, "Advertising is the art of arresting human intelligence long enough to make money out of it."



Does advertising really work? Frank Simoes, an advertising professional, considers it an asinine question. He has quoted the example of a highly successful Indian campaign of the 70's to promote a bust developer. It was a metal and spring device that needed strenuous effort, high pain tolerance and intense will power to make its wonders work. But the advertisements showing *Before* (pity!) and *After* (oomph!) pictures of female busts worked like magic. Thousands of women from all over India rushed mail orders. It was a resounding testament to the triumph of hope over reason (Simoes F, 1993). The silent sufferers ensured that the truth of the matter remained unknown for long (see *the silent sufferer* in ch. 9).



We should realise that the ethical dimension in health care advertising is different. In consumer goods, the target of advertising and the consumers of the products are the same. In contrast, the target in health care is the health professional but the consumer who pays the bill is his/her client. Can we then permit no-holds-barred promotional efforts aimed at the health profession while the consequences of such unbridled promotion are faced by unsuspecting health care seekers?

Do not think, "It is peanuts." Allopathic drug industry spends roughly 20% of its sales income on promotional efforts. It is about ten times more than what is spent on research and development! Currently, the annual sale of the allopathic drug

industry is over Rs 10,000 crores. If 20% (Rs 2,000 crores) is spent in promoting drugs to about 500,000 (allopathic) health professionals, it amounts to Rs 40,000 per person per year. In other words, an average doctor is the target of promotional efforts costing Rs 3,500 every month and in return, he/she prescribes drugs to the tune of Rs 17,000 to his/her patients!

Though most health professionals believe that promotional efforts do not influence them, the sales professionals know better. Analysis of the top selling drugs of 1993 reveal that 22 of the top 100 drugs are nonessential. Most of them do not find a place in any text book or unbiased scientific literature. Yet, the total sales of these 22 drugs amount to nearly Rs 300 crores! It is entirely due seductive promotional pressure exerted on the prescribers by overt and covert means.

'No raindrop feels responsible for the deluge' *and no doctor feels responsible for such a colossal waste of the society's resources*. But it is a matter of collective shame. Three hundred well-equipped health centres could have been created with the money wasted on the top 22 non-essential drugs every year!

Ayurvedic drugs used to be sugar coated and were successfully marketed as pseudo-allopathic or 'allovedic' drugs. Such remedies were enthusiastically prescribed by many allopathic doctors who knew next to nothing about the innumerable ingredients in each of those formulations. Under sustained promotional pressure, these drugs worth crores of rupees were prescribed while the drug regulatory agencies and Medical Councils looked the other way. In 1996, the Supreme Court had to drive some sense into the minds of practitioners by declaring such cross-practice illegal (see ch. 15).

In the hard hitting book 'Deception by design', Joel Lexchin (1995) raises the query "How does the industry promote?" He

goes on to answer it thus: "By using too many detailers with too little knowledge, by dumping 'free samples', by raising the sale-price, by offering bribes euphemistically called gifts, dinners, travel, etc., and by conducting bogus clinical trials and biased conferences."

Similar aggressive promotion is targeted directly at the public while pushing the sales of irrational over-the-counter remedies. I have treated persons who wished to "energise themselves with glucose" but ended with frank diabetes.

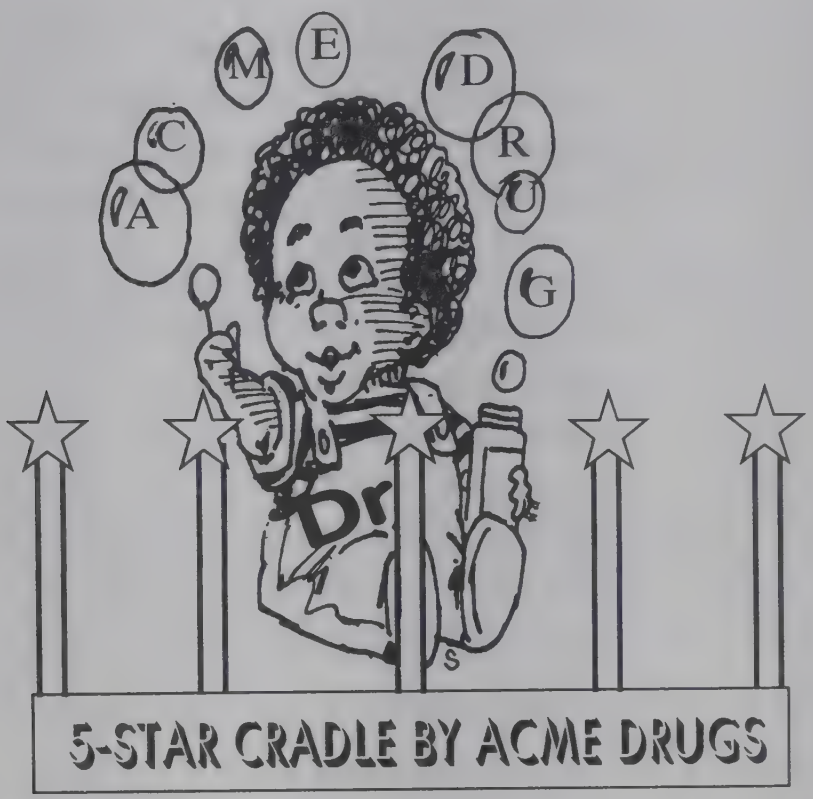
Self regulation by any for-profit industry is a myth or a mirage. Andy Chetley, in his foreword to 'Deception by design', has this to say: 'If some one proposed that those charged with a crime could form a committee of judges, enlist colleagues and good friends as lawyers and jury to hear the case and pass sentence, we would dismiss the idea as too ridiculous for words. Yet the world's pharmaceutical industry offers just such a solution to the problem of inappropriate drug promotion.'

Wasteful misuse of nonessential drugs will reduce only if all the four stakeholders act in harmony:

- The governmental decisions should be people oriented and consumer friendly.
- The public should not be gullible but be enlightened and realistic.
- The health professional should be ethical and rational and not a 'pill-peddling robot'.
- The industry should be value based and nonexploitative.

Among the stakeholders, the role of professional groups is perhaps the most crucial. The Indian Academy of Paediatrics has shown the way for other professional groups by its two

successful campaigns on oral rehydration therapy (ORT) and breast milk, and by its successful fight against unethical milk food promotion. Every Indian should applaud these collective actions taken by the child-specialists over the past two decades.



- When will the other professional bodies grow up and get out of their "5-star cradles" sponsored by the industry?
- When will they show concern for people's welfare and tell the unethical promoters 'enough is enough'?
- They can do it if they place their *conscience before comfort* and their *hearts before their stomachs*.
- They can do it if they stopped being such '*gullible crows*' and '*feeding the clever foxes*' with their prescriptions.
- But do they have the conviction and collective will-power?

27. Competence or *Numero uno*?

The Eagle and the roosters: *Once there were two roosters in a farm yard who fought to decide who should be the master of the farm yard. The fight was over when the loser ran away and huddled in a corner. The victor flew up to the top of the haystack and crowed to the world that he was the master. An eagle spotted him from above, dived on him and carried him off. The other rooster came out and ruled the roost.*

There were two professors in an institution who used all their energies in proving that one was senior to the other. Finally, one professor was designated as the official head of the institute and the other relegated to the background. However, the joy was short lived for the *numero uno* as he was promoted and transferred to an administrative post at the centre. The second professor took charge of the institute while the senior one was soon lost in a maze of red-tape.

Comments

The 'Numero uno' game is played out in corporate practice, in research institutions and in academic circles. Ego problems, litigations, fights for seniority, etc., interfere with their main function as health professionals. Many institutions, hospitals and colleges become dysfunctional because of such bickering among the elite.

The 'Peter principle' states that, in a hierarchy, the individual rises further to reach his/her level of incompetence. To remain a competent worker, he/she should stay put at the most competent level of functioning and refuse the seductive offers of promotion or transfer (Peter L, 1969). This calls for a unique combination of contentment, self-esteem and self-realisation.

It is indeed quite rare! The result is that many competent and respected health professionals end as weak and ineffective administrators. It is a tragic loss of professional talent. Human resource managers ought to follow the 'Peter prescription' to avoid such a loss of professional talent.

28. Revenge is double-edged

> ***The Farmer and the Fox:*** *A farmer was troubled by a fox that kept stealing his fowls at night. He set a trap and caught the fox. As a punishment, he tied a bunch of tow to its tail and set it on fire. The fox ran helter-skelter through the ripe cornfield. The field was soon on fire and the farmer lost his harvest.*

A community of a consumerist society was greatly annoyed by the health care providers who, they felt, were exploiting the ill and vulnerable to accumulate wealth. Once, in a case of negligence in obstetrics (midwifery), the jury felt it justifiable to slap a stiff penalty on the erring doctor and send a clear message to all the doctors. The penalty was so stiff that the insurance premium for obstetric negligence skyrocketed. Most of the obstetricians migrated to neighbouring states rather than pay such high premiums for insurance cover. The end result was that the community had to travel 100 to 200 Kms to a neighbouring state for delivery under proper obstetric care.

Comments

Prof S Chandrasekar, my guru, used to tell us, "There are no guarantees in Medicine. For us, 'Always' means *most of the time* and 'Never' means *hardly ever*." This reality has to be understood by the professionals and accepted by the society. Under the present tort system of redressal, the 'victim' has to

prove that the care provider was negligent. The system promotes 'ambulance chasing lawyers' who specialise in finding faults in the health care services to get compensation awarded to the client. Doctor-patient trust gets ruined in the process (see ch. 19 for a discussion on accountability).

Universal no-fault health and life insurance is a better way of compensating those who experience an adverse outcome after diagnostic or treatment procedures. No-fault insurance is already practised in India to provide compensation for traffic accidents. A similar system should be evolved to cover health care mishaps. The practice of defensive medicine (overuse of tests and therapies) may then reduce greatly.

Revenge hurts both the parties and kills doctor-patient trust. No-fault insurance is a way out. We have to campaign for it. But who will bell the cat? The consumer activists can do it. They should.

29. Over confidence leads to disaster

The mule, the rooster, and the Lion: *A mule and a rooster lived in a farmyard. A lion sneaked in and was about to pounce on the ass, when the rooster, realising the danger, rose to its full height, flapped its wings and crowed lustily. The lion was scared by all the racket made by the rooster and beat a hasty retreat. The mule was pleased to see the fleeing lion and thought, "If a small rooster can scare him away, I can chase him too." He pursued the lion to the fringes of the jungle when the lion suddenly turned around, pounced on the mule and devoured him.*

Dr Prakash was a brash young surgeon who was rearing to start independent practice. "Don't be an ass," advised his teacher, "you are not ready yet. You are protected here so well that you don't even realise the dangers of independent practice." But Dr Prakash replied, "Sir, in the past two months, you have just stood and watched me do everything. Not once did I need any help from you."

He left the institute and started his private practice. As ill luck would have it, the first 'acute abdomen' he opened was a problematic case. The patient died and Dr Prakash was charged with manslaughter by the relatives.

Comments

Many young enthusiastic health professionals suffer from the 'almighty syndrome'. With the newly gained scientific information and skills, they are ready to take on the world. However, converting mere information into useful knowledge takes time. Gaining insight and wisdom by repeatedly applying one's knowledge takes even longer. Similarly, gaining mastery over skilled procedures takes time and practice.

Health care seekers should learn to spot the signs of over confidence in a professional. Such a personality -

- talks in absolutes like never, always, absolutely, etc.
- is brash and over-optimistic in 'pushing' of procedures.
- bypasses or smooth-talks on queries about risks involved.
- is unidimensional, i.e., unable to discuss pros and cons of a complex case in a holistic way (Scully T, 1987).

Young professionals should be proactive in outcome and impact analysis. *Modern miracles in health care are as potent as they are double edged.* The potential risks and adverse outcome should be explained to the patient or a responsible relative (see ch. 1). With facilities like the internet and tele-conferencing, novices should take help from their teachers and seniors. As the cliche goes, it is better to be safe than sorry.

30. Notoriety and Fame

> ***The Mischievous Dog:*** *There was once an aggressive dog who used to bite people without any provocation. He was a nuisance to the visitors who came to his master's house. The master fastened a bell around the dog's neck to warn the visitors. The dog was proud of the bell until an old ox came up to him and said, "Don't think the bell is a compliment to your good behaviour. On the contrary, it is a badge of disgrace."*

Comments

"The medical profession, like the other professions, consists of a small percentage of highly gifted persons at one end and a percentage of disastrous duffers at the other." (Bernard Shaw, 1906). The notorious among them perform unethical procedures like illegal kidney transplantation, the enforced removal of the uterus of mentally challenged women, covertly helping people to commit suicide and prematurely performed dangerous experimental surgery like pig heart transplantation. There are some others who falsify research findings and are notorious in the professional circles.

On the conscience of such doctors, Shaw has said, "The human conscience can subsist on questionable food... the man

who does evil skilfully, energetically, masterfully, grows prouder and bolder at every crime." So much so that notoriety feeds on itself to attain monstrous proportions. It is the moral obligation of regulatory bodies and professional groups to identify notoriety and nip it in the bud.

Notorious acts by professionals without conscience have to be condemned in no uncertain terms. But excessive media attention in a non-judgemental manner seemingly converts notoriety into fame. A notorious act becomes a 'million dollar story' and the perpetrator can literally sell it for a pot of gold.

If the society tolerates notoriety and permits these bad role models to flourish as 'rich and famous', it is bound to influence young impressionable minds adversely and propagate notoriety. The recent boycott of the *paparazzi* and their prized photographs by the media after princess Diana's death is a change in the right direction. Can the media go further along the ethical path?

31. Bad trait persists

> ***The Ant:*** *It is said that, once upon a time, the ants were tillers of the soil who raised crops. But they were a discontented lot, always envying the yield in the neighbours' farms. They stole the produce from other farms whenever they got a chance. Jupiter got so angry at their greed, avarice and covetousness that he turned them into ants. Though they became tiny ants, their behaviour remains same to this day. They continue to steal food from others and store them for their own use.*

Dr X was a compulsive skirt-chaser since his student days. Women health professionals and nursing staff kept a safe

distance from him. Then he was found unnecessarily disrobing female patients who were under his care and intensely examining them for unduly long periods. He was shifted to the children's ward. There he got into the habit of personally supervising breast feeding of infants by young mothers. Soon some young women complained about his frequent attempts to handle their breasts.

He was then shifted to a geriatric ward where only elderly men were admitted. Things seemed quiet for sometime. Then he cast his eyes on the young and attractive women who visited their relatives admitted in the ward. Once, a ward nurse spotted him with a young female visitor in the treatment room. He was apparently trying to examine her, against her will, to look for any evidence of the 'chest condition' her father was admitted with. He was then suspended and asked to leave the hospital.

He went to a Gulf country. Two years later, he was arrested there for misbehaving with a female patient.

Comments

Alcoholism, drug-addiction, avarice, philandering, and major psychiatric problems are some undesirable traits found in some health professionals. These traits may directly or indirectly harm the patients under their care. "Until there is a practicable alternative to blind trust in the doctor, the truth about the doctor is so terrible that we dare not face it. Not only is the first class man set to do third class work, but *what is more terrifying, the third class man is expected to first class work.*" Bernard Shaw might have overstated his case; nevertheless, there is much truth in it (see ch. 2).

The professional colleagues, who usually spot these first, face the ethical dilemma of protecting a colleague or protecting

his/her unsuspecting patients (see ch. 16). The spirit of guild and collegial loyalty are often stronger and prevail. Some rationalise thus: "It is only a random aberration and he won't repeat it." The result is that an unworthy colleague escapes and the public may continue to suffer because of this protectionism.

Shaw had some strong words on this too. He said, "Every doctor will allow a colleague to decimate a whole country side sooner than violate the bond of professional etiquette by giving him away. He is not sure enough of his own opinion to ruin another man by it." The Medical Councils should be more pro-active in identifying and weeding out the "bad apples" from the profession.

Meanwhile, if you are a woman, you should be able to spot a 'Don Juan' and protect yourself in a hospital. Intrusive body language that makes a woman uncomfortable is the first clue. Suggestive remarks and smooth-talking may be more difficult to decipher.

Not keeping a female attendant like a midwife or a nurse while examining a woman is by itself an unethical act. Warning bells should sound if any such attempt is made. You should insist on a female attendant, at least another female patient or a relation to stand by your side before submitting to an examination or a procedure by a male. If your request is ignored and an attempt is made to undress you or close the door and dim the lights in the room, you are justified in running out and raising an alarm. You can also be proactive. Get the names of male professionals and nurses who attend on you in a large hospital. Insist on a female attendant. Crooked female nurses are also known - so watch out! A well-lit room and an open door are much safer than a dark room with bolted doors.

If you are a young health professional, remember that *modesty has no age-bar*. Young male doctors at times carelessly handle women patients - "old enough to be my mother" - and are shocked if complaints are lodged against them for a misdemeanour (see ch. 41).

Like Caesar's Wife, always be above suspicion.

SECTION - III

COPING WITH HEALTH CARE

The meaning of a crisis lies not in the situation but in the interaction between the situation and the ability of the person to successfully cope with it.

(WI Thomas)

INTRODUCTION

The ability to cope with a problem depends on the *preparation* of an individual to meet the threat and the *motivation* of the individual to meet the challenge. To state an analogy, preparation is taking a horse to water; motivation is what the horse needs to drink it.

Coping Strategies

People adopt several strategies to cope with a crisis. Psychologists have classified them as *maladaptive* if the strategy hinders and *adaptive* if it helps to overcome the crisis. Health care providers and care seekers use the following strategies to cope with health related crises.

- Anticipatory problem solving: e.g., "I made a plan of action to cover all eventualities and stuck to it till the end."
- Positive reappraisal: e.g., "I came out of the experience as a better person. I found new faith."
- Self control: e.g., "I kept others from knowing how bad things really were."
- Dependence on social support: e.g., "I contacted all my well wishers and got their advice and sympathy."
- Confrontation: e.g., "I grappled with it and would not let go until some result was achieved."
- Accepting Responsibility: e.g., "I realise that I have created this crisis by my actions."
- Distancing or Denial: e.g., "Nothing has really happened. You people always exaggerate."

- Escape or Avoidance: e.g., "I don't have to do any thing now. The problem will vanish soon."

Depending on the nature of the crisis, a given strategy may be adaptive or mal-adaptive. Usually, denial and avoidance are maladaptive and do not help in resolving health care crises.

In this section, coping strategies adopted by health care seekers and providers have been combined. The main under-current is that *in health care crises, things are often not what they appear to be and one needs to have a holistic perspective to cope with them rationally.*

32. Rationalising

> ***The Fox and the Grapes:*** *A hungry Fox was attracted by some fine bunches of grapes hanging from a highly placed vine. He tried to reach them by jumping high in the air but it was all in vain. So he gave up and walked away saying to himself, "I thought the grapes were ripe but now I know that they are sour."*

Muni, a farm labourer, had a chronic heart disease and was on medications. He was advised to undergo a heart surgery to improve the quality of his life. He tried his best to raise the necessary funds but could not do it. So he gave up trying and said, "I thought that the operation meant freedom from taking drugs, but it is not so. All the operated persons also take drugs. I see that the operation is not useful." and went back to taking medicines.

Comments

Rationalisation is a thought process by which one attempts to justify one's action by distorting the truth consciously or

unconsciously. In the case of Muni, surgery was advised not to stop taking drugs but to improve the quality of life. Since he could not afford it, he distorted this by relating surgery to freedom from drugs.

Many psychologists believe that rationalisation as a coping mechanism is a web that conceals internal conflicts, disappointments, or anxiety. It is a protective mechanism that makes the person forget the source of anxiety or disappointment and carry on with life. Rationalisation is perhaps a better coping mechanism than some other destructive behaviour.

33. Acceptance after analysis

> ***The Peacock and the Crane:*** *A peacock showed off his brilliant plumage and taunted a crane, "Poor dear! How dull are your feathers." The crane replied, "No doubt, your plumage is glamorous. But my feathers help me to soar into the clouds while your plumage confines you to the ground like any dung hill rooster."*

Dr Singhal, a university professor, had angina (chest pain) on walking twenty steps at a normal pace. Adequate medical treatment gave only partial relief and he was advised to undergo coronary bypass surgery. He learnt that the risk of dying of the surgery was about 2%. He decided to postpone his surgery.

"But you can't go on living like this - like a cripple," chided his close friend Mr Moorthy, "Look at me. I got the bypass done. I am fine."

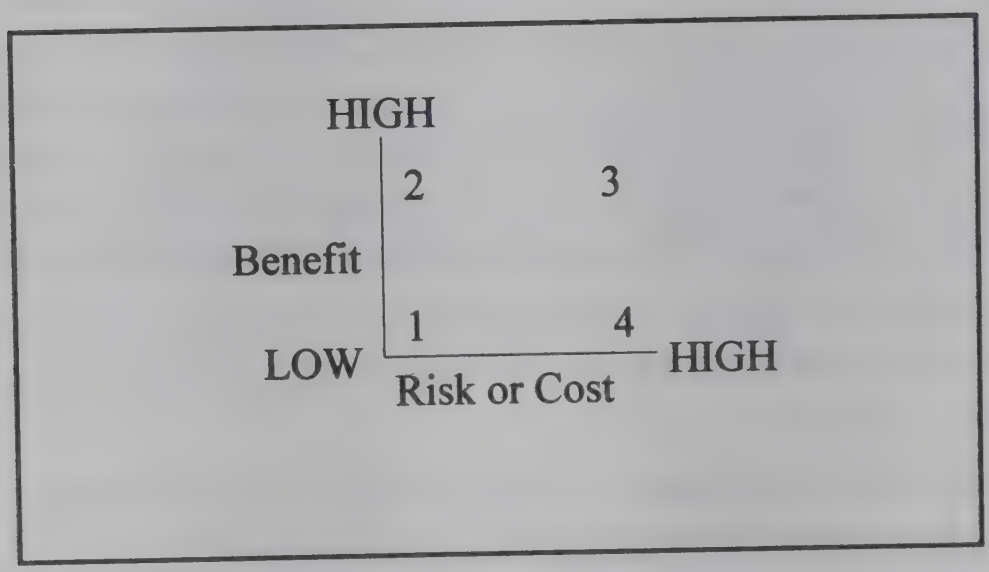
Dr Singhal replied, "You are right, Moorthy. But my daughter Pooja is doing her MBA. I want to be around to ensure that she gets a good job and a good husband. I have lived with

angina for the last six years. A few more months of the same are acceptable to me than the risk of surgery." He continued to be on drug treatment for two more years. He was fortunate in not getting any worse. Meanwhile her daughter got employed and got married. Then he underwent a successful bypass surgery.

Comments

Any health care option can be analysed in terms of benefits, risks and cost. The benefits have to be weighed against the risks and against the cost. An enlightened health care seeker like Dr Singhal can cope with a difficult decision making process through analysis. Any professional should encourage such patients to take decisions instead of being paternalistic and talking down to them.

Cost-benefit and risk-benefit can be simplified into four categories (See box).



Category 1: A) Low risk - Low benefit
B) Low cost - Low benefit

These are mostly rituals in health care that are routinely done. "Why not try it? After all there is no harm" or, "It does not cost much and may do some good" are the arguments put forth to promote these options. These are acceptable options but may not be of much use.

Category 2: A) Low risk - High benefit
B) Low cost - High benefit

These are ideal options to be avidly accepted. "It is safe and dramatically improves the outcome" or, "You can't get a more affordable option. It is a steal" are the arguments put forth to promote these options.

Category 3: A) High risk - High benefit
B) High cost - High benefit

Many modern miracles of health care belong to this category. Some examples are transplantation, assisted reproduction, foetal surgery and cancer chemotherapy. No doubt, the benefits are great, but one has to accept considerable risks and be prepared for short term and long term expenditure. Quite often, health care providers and the media highlight the benefits and understate the risks/costs. Care seekers may mistake these options to be of low risk or low cost. If they burn their fingers due to unaffordable costs or an adverse outcome, they may react badly and seek redressal.

Many health care litigations in court arise from mistaking a category 3-A option as a category 2-A option. Proper pre-treatment counselling is the only effective way of preventing such mistakes.

Category 4: A) High risk - Low benefit
B) High cost - Low benefit

Some researchers wanting to be the first to prove a point may actively pursue high risk-low benefit options. High cost-low benefit options are promoted by the health industry that looks for newer ways of making profits. We should weed out such options from health care.

A desperate care seeker is often asked, "What other chance do you have" to justify a category-4 option. Such pursuit of the margin of the impossible is an example of *technological brinkmanship* in health care (Silverman WA, 1995).

TS Eliot has warned us against action taken *"not for the good it will do but that nothing be left undone."* Empower yourself to cope with health problems by a careful analysis. Consider the benefit, risk and cost before making a decision. Help your doctor to help you better. In short, be smart.

34. Unquestioning Acceptance

> ***Jupiter and the Monkey:*** *Jupiter organised a show where all the beasts could bring their offsprings. The best offspring in Jupiter's opinion would get a prize. A monkey brought her offspring, a hairless, flat nosed little fright. On seeing it, Jupiter and all the other gods burst into laughter. The monkey hugged her little one and told them, "You may give your coveted prize to any one you like the best. But to me, my baby is the most beautiful of them all."*

Uma, a bank employee, gave birth to a spastic child. The relatives advised her to institutionalise the child and said, "After all you are young. You can get another baby. It will be

healthy." But Uma was firm and told them, "The apple of my eye need not be yours too. Ganesh is a special child. I will look after him." To ensure giving her undivided attention and raise Ganesh, she did not conceive again.

Comments

Uma is a role model of an ideal mother. She is real. I know some more like her. But most parents expect the ideal height, ideal weight, ideal features and complexion in their children. The societal concept of 'ideal' is often what is portrayed in the media. Majority of people look down upon persons with less than ideal characteristics. They may institutionalise these unfortunate persons, and enforce drug treatment or unwarranted surgery like hysterectomy upon them. Once, I was approached by a middle class mother of a 16-year old infantile dwarf girl. She offered her child for *any kind of research purposes*, but only if we promised not to hand over the girl back to her!

Enlightened public should accept non-modifiable factors in individuals and manage them in a humane way. Like Uma did.

35. Creative problem solving

The Crow and the Pitcher: *A thirsty crow at last located a pitcher with some water in it. Unfortunately the water level was so low that the crow could not reach it. It appeared to be a case of so near and yet so far. The crow suddenly thought of a solution to the problem. It picked up small pebbles and dropped them into the pitcher until the water level rose to the brim of the pitcher. The crow quenched its thirst and happily flew away.*

Neethi was born with multiple birth defects that needed corrective procedures. Her parents encouraged her to study and get ahead in life. She developed into a vivacious person with never-say-die spirit. She planned a career in Medicine to take care of herself.

At the age of 20, she developed late complications and needed a series of corrective operations. She then decided to go to USA. She qualified and migrated there to get treated and to practise medicine.

Comments

A typical Indian family considers a girl child with birth defects as a curse. The child is diffident, pessimistic and lacks self-esteem. She hides herself and never develops to realise her true potential. We need to adopt creative problem solving to cope with such problems.

Dr Stephen Hawking, a world renowned theoretical physicist, is another inspiring example of creative problem solving and never-say-die spirit. When he was in college, he showed signs of a progressive and fatal neuromuscular disease. Hawking learnt that his thought process will remain intact until the very end. He changed his study subject to theoretical physics and has done outstanding work in that field.

Though his physicians had predicted survival for about three years, he has lived for a quarter centuryand still going on. He is almost totally paralysed and needs a machine's help even to breathe. But he still works and gives scientific lectures through a computerised voice synthesizer!

Persons like Neethi and Dr Hawking are role models for coping through creative problem solving. There are many more

like them. The media must throw a spotlight on such persons. Instead they tend to sensationalise destructive coping behaviour like assisted suicide and homicide.

In health care, the 'Jaipur Foot' can be cited as an exemplary creative problem solving done by an Indian doctor. It has put so many amputees back on their feet at an affordable cost.

36. Being smart

The Old Lion and the Clever Fox: *An old enfeebled lion was confined to a cave. He got his meal by pretending to be sick, coaxing other animals to attend on him and devouring them at an opportune moment. Many unsuspecting animals had lost their lives this way. One day, a clever fox called on the lion. He stood outside the cave and exchanged pleasantries. "Why don't you come in and look me up?", asked the lion. "I better not do that," replied the fox, "for I notice a lot of foot prints going into the cave but none that come out," and walked away.*

Seema was pregnant. She wished to register with a nursing home to monitor her progress and conduct the delivery. She went to Acme Nursing Home. At the reception, the public relations officer (PRO) was most cordial. "Obstetric monitoring and delivery? Madam, you have come to the right place." he told her while handing over a brochure of the hospital that listed its facilities and statistics. He asked her, "Madam. When can I fix an appointment with the doctor?"

"Not so fast," Seema thought to herself and browsed through the obstetric statistics. She smiled wryly and got up to leave the place. The PRO explored, "Anything wrong, Madam?"

Seema waved the brochure and replied, "Yes. I think so. During the last year, you have admitted about one thousand obstetric cases and I see that you have done more than nine hundred caesarian sections. I want a hospital which promotes normal delivery," and walked out.

Comments

The rate of delivery by caesarian section is very high in private hospitals. My student reports that, in a small nursing home where he had worked for six months, caesarian section was the norm and "normal delivery" was an exception. Unnecessary surgery is neither confined to India nor to Obstetrics. In an audit, three quarters of appendices removed in Germany were found normal.

Dr R Mendelson (1981) mentions the following "Don'ts" in his book 'Malpractice' to help avoid unnecessary surgery:

- Don't assume that the operation is necessary.
- Don't assume that the surgery will make you feel better.
- Don't assume that the surgeon cannot make mistakes.
- Don't assume that all the treatment choices have been considered.
- Don't be deceived by a well-polished air of confidence.

Being smart in analysis

When you feel ill and go for medical opinion, ask yourself the following six questions:

i) Does the medical diagnosis seem to fit in to your view of the situation (illness)?

ii) If there is a wide gap between the diagnosis offered and your feeling of illness, does the health professional convincingly explain the apparent disease-illness mismatch?

iii) What are the various treatment options?

iv) What are the risks, benefit and cost of each option? Can I afford the costs? Can I accept the risks?

v) What is the natural history of the disease? Will it recur? Will it subside on its own?

vi) Is the treatment for symptom control, containing damage, cure or rehabilitation?

When in doubt, get a second opinion, preferably from a non-profit service sector.

Being a smart care seeker

How to be smart in seeking health care? Here are six suggestions:

- Be friendly. You are, in fact, a "co-producer" and an equally responsible partner in your own health care and recovery.
- Get the names of health care workers and professionals who take care of you.
- Get bills for all payments made.
- Collect a copy of the case file. You have the right to possess a copy, if not the original records.
- Collect all the test reports and images. Some images and tissue samples need processing time. Remember to collect them later.
- Try to develop long term rapport with trustworthy providers. There are plenty of them too!

To put yourself in the right frame of mind, remember that *you are the employer and the professional is an employee* (Fulder S, 1991).

37. Crying for help

> ***Hercules and the Waggoner:*** *A waggoner drove a loaded wagon when its wheels sank into the muddy road. His horses could not pull it out of the mire. He wrung his hands helplessly and wailed aloud requesting Hercules to help him. After a while, Hercules himself appeared and said, "Put your shoulder to the wheel and goad your horses. Then you may seek help. If you will not lift a little finger to help yourself, you can't expect God or anyone else to come to your rescue."*

Mohan, a 35-year old businessman, developed multiple sclerosis - a chronic disease of the nervous system with an unpredictable course of recoveries and relapses. On realising the nature of the disease, he was devastated. His initial attack was mild and resulted only in a partial paralysis of the legs from which he could have made quick recovery. The physician told him, "Mohan, try hard and you will be back on your feet in four weeks." The physiotherapist tried to motivate him to perform exercises. But he pleaded helplessness and made no real effort to move his legs.

When Mohan asked his physician, "Doctor, when would I recover and go home?", he replied in an exasperated tone, "My dear young man! I have to ask you that question. When would you try to recover and go home? Simply lying down pleading to be powerless won't get you anywhere. When you decide to take charge of your recovery, we probably can help you, but not until then."

Comments

The ability to recover from a setback and bounce back to full life varies from person to person. It has been called the *spiritual factor* or *Factor-X* in healing (DB Bisht, 1985). It has been estimated that 15 to 20% of healing is due to this factor. Persons with poor factor-X recover poorly and slowly after any illness. Faith in oneself, in a *guru* or in God seems to be necessary to get the power of factor-X.

I have collected the case details of quite a few persons with low factor-X. They are well educated, cynical, pessimistic and unable to have faith in themselves or any one else. I vividly remember a health professional who could not recover from her symptoms even after a successful heart surgery. No amount of explaining, counselling or placebo therapy helped her to resume normal activity. Finally, I had to coax the priest from her church to visit her and try to prop up her spirits. The priest had to work very hard in her case to achieve a measure of success and she could walk home on her own after a few weeks.

38. Complaining

a) ***The Oxen and the Axles:*** *A pair of oxen were pulling a loaded wagon along. As they strained to pull the load, the axles of the wagon creaked loudly. This irritated the oxen who said testily to the axles, "Keep quiet! Why do you make so much of noise when we do all the work quietly?"*

When Meena was admitted for treatment of high fever, her husband Kumar was upset. He complained to the doctor, "I have to do all the household chores and look after the children now. Can't she stay at home and take the treatment?" The

doctor replied, "When she does all the household chores, you don't even notice it or try to help her. But when you have to manage it for just a few days, you complain so much." He coaxed a reluctant Meena to stay in the hospital until she was really well.

b) ***The mule and his Masters:*** *A mule had a hard time with his master, a gardener, who gave him much work and little food. The mule begged Jupiter to take him away from the gardener to another master. Jupiter arranged to sell the mule to a potter. The work with the potter was even tougher and so the mule begged Jupiter for another change. Jupiter obliged and sent the mule to a tanner. When the mule saw what the tanner did for living, he cried in despair, "Why did I search for an ideal master to suit my taste? My former masters would have at least given me a decent burial but now I shall end up in the tanning vat."*

Babu, a 40-year old diabetic, was fed up with daily insulin injections. "I can't take them for the rest of my life," he said to himself and shifted to another system of medicine. There, he had to be follow a very strict diet and an exercise programme. He also had to take bitter herbal preparations. He could not stand it beyond 3 months. He then consulted a "polytherapist" who combined magnets, gem and aroma therapies to control his symptoms. He rapidly worsened and was admitted in a state of 'diabetic coma'. Insulin was restarted and he survived. Then he stopped complaining and took 'the injections'.

Comments

One must learn to count the blessings, instead of wallowing in the misery of self-pity and chronic self-absorption. It is quite common to see persons with chronic lifelong problems like

diabetes complain bitterly about the illness or the treatment and speak for hours in this manner.

The average survival of a young diabetic used to be just three months before insulin injections were available. Now it is possible to live a full life despite diabetes. When a diabetic complains of needle-pricks for life, the physician has to counsel and motivate him/her to see reason and count the blessings.

A similar responsibility of being a counsellor and an adviser falls on the physician when the relative of a patient, usually the husband, complains about 'having to manage while *she enjoys her rest* in a hospital'. If the patient is submissive to his demands, she may deny herself proper health care and rest. In the end, this will be counter productive. Despite the current craze for 'patient autonomy', I believe that *judicious paternalism by the treating physician is ethical and warranted in managing such cases.*

39. Non-compliance

The mule and his Burdens: *A tradesman bought two sacks of salt, loaded them on his mule and was returning home. On the way, while crossing a stream, the mule fell down by accident. When he got back on to his legs, the burden was much less as much of the salt had dissolved away. The tradesman went back to buy more salt and was again on his way home. This time around, the mule feigned a fall and lay down in the stream to reduce its burden of salt. The master detected the trick and turning back again, he bought a huge pile of sponges and loaded it on the mule. While crossing the stream, the mule sank into the water. Alas!*

When he tried to get up, the burden was much heavier, as the sponges had soaked up much of the water.

Ravi, a 45-year old businessman, felt cramped by all the lifestyle changes advised by his doctor to control his diabetes. He did not follow any of the advice except for two days before the next check up and blood tests. He could fool his doctor initially but later the doctor suspected non-compliance. The doctor ordered a special test (glycosylated haemoglobin) that reveals control of diabetes over the previous three months. Ravi's non-compliance was thus exposed.

Comments

Doctors tend to overestimate compliance of their patients (Norrel SE, 1981). They often presume that all the patients diligently follow their advice. The patients may feel burdened by treatment advice especially the life style changes and unpleasant procedures or medications. "You must take it. It is for your own good." is all that most doctors can say to coax their patients to comply with the treatment.

Over the years, I have come across the following reasons for non-compliance and non-adherence:

- *Misunderstanding of the nature of the disease:* Patients with diabetes or high BP may assume that one course of treatment will cure the disease. Many chronic health problems need lifelong monitoring and follow up. Effective counselling on the nature of illness may reduce this form of non-compliance.

- *Wrong assumption that "control is cure":* This is an extension of the previous fallacy. A patient takes medicines only until blood pressure, blood sugar, etc., normalise. Then they stop all treatment thinking that the disease is cured. Pro-

active advice like, "When values reach normalcy, you have to go on to maintenance therapy; do not stop it." may help avoid such non-compliance.

- *Misunderstanding of the name of a drug or its dosage or duration of treatment:* Effective communication, especially when written in a language that the patient can read, reduces this form of non-compliance. Patients should not feel delicate to clarify all their doubts regarding treatment.

- *Fear of addiction and fear of 'potency' of the drug:* Media reports of the panic-mongering type are usually followed by an epidemic of this form of non-compliance! Patients must openly discuss their fears with their doctors and get clarified on risk-benefit ratio, any potential for addiction or adverse reactions.

- *Mistaking "illness" for "disease":* Though the terms disease and illness are interchangeably used in the health profession, medical anthropologists make a clear distinction (Sachs L, 1991).

ILL - NOT DISEASED

Disease is what is diagnosed by the health professional. It is the abnormality (pathological state) of the body or mind. *Illness is what is perceived by the person with or without a disease*. It is subjective (Fitzpatrick R, 1984).

DISEASED - NOT ILL

In many diseases like high blood pressure, diabetes and early cancers, a patient may not feel ill at all. On the other hand, in benign conditions like tension headache and irritable bowel syndrome, the patients may perceive a severe illness but their doctors may say, "You do not have any disease - all the tests are normal."

It is important that health care seekers and providers understand the concept of illness and disease and the possible paradoxical relationship between them. A rational approach to disease-illness mismatch is the only way to reduce non-

compliance among those with a "chronic disease without illness." It is also the only way to reduce *doctor shopping* by those with a "chronic illness without disease."

■ *Social-cultural-religious barriers:* Social events disrupt the schedule of an otherwise compliant person. A happy event like a wedding or a sad event like death results in temporary non-compliance because taking treatment does not seem terribly important then.

I know of a young diabetic who undertook pilgrimage to Sabarimala to get rid of his 'diabetic problem'. He stopped taking daily injections of insulin. On his return, he went into near coma due to very high blood sugar and was admitted for control.

I also know of a Muslim diabetic who thought that all insulin was extracted from the pigs. He never verified his suspicion with any one else. After nearly two years of non-compliance, he finally confided in me.

There are deep rooted social, economic, cultural and religious barriers to compliance. Health activists! This is an area for you to run a major campaign. It will empower care seekers to utilise the health care services better.

■ *Non-compliance by denial:* Denial is one coping mechanism that always results in non-compliance. This is the most difficult to manage. Unless the provider-client relationship is strong, mutually respectful, and can address the deepest concerns and fears of the client, the barrier of denial cannot be breached.

Once, a nuclear engineer consulted me for a health check-up. He had severe narrowing of the aortic valve that resulted in

a great strain to the heart. Unfortunately, he had only minimal symptoms - another case of 'disease-illness mismatch'. He denied that he had any serious disease and did not comply with my advice to consult a cardiac surgeon. Next year, he visited me again for a checkup. Obviously he had felt that I was a well-meaning physician who tends to overstate things! I verified the physical findings. There was no doubt that he had severe aortic valve disease but how could I convince him of that?

I told him, "Sir, you are a nuclear engineer and an expert in your field. I acknowledge that. Similarly, I want you to consider me as an expert in my area of training. Otherwise, you would not consult me twice. You do have a serious obstruction of the aortic valve. By the time you get symptoms, it may be too late to operate." He listened to me but without any conviction.

I then threw him a challenge. "You please consult any heart surgeon of your choice with my referral letter. If he or she disagrees with my diagnosis, I will surrender all my degrees and stop practising medicine."

That stunned him. He realised that I really meant what I had said about his heart valve. Next month, he consulted a surgeon in Mumbai. He was successfully operated within a week. He has become one of my fans and sends me a greeting card now and then.

After this experience of 1982, I occasionally use this '*surrender my degree and stop practising medicine*' ploy to break the denial barrier of tough non-compliant cases. I am yet to surrender any of my degrees! Touch wood!

An empathic care provider should discuss non-compliance openly and non-judgementally. He/She should respect the patient's wishes and design a workable plan of treatment.

40. Plodding, and Procrastinating

The Hare and the Tortoise: *A hare teased a tortoise for being so slow on its feet. The tortoise challenged the hare to a race, and dared it to win. The hare readily agreed and was amused at the idea of running a race with such a tardy rival. A fox agreed to be the judge and the race was started. Soon the hare was so far ahead that he thought of taking a brief nap and then resuming such an one-sided race. While the hare was fast asleep, the tortoise kept plodding on and in time reached the finish line.*

Hari and Thomas were attending the same chest clinic for treatment. Both had a chronic lung condition called bronchiectasis. Their doctor explained to them the nature of the disease and how to take proper care: "The normal lung has a clearing mechanism to remove the germs and dirt particles along with the phlegm (mucus). In bronchiectasis, this mechanism fails. So every day, you have to adopt head down postures and drain the mucus using the pull of gravity. You must do this lung-toilet twice a day. Otherwise the mucus will stagnate, cause repeated infections and slowly destroy the lungs." They were also taught to look for early signs of chest infection and take the appropriate treatment.

Thomas was meticulous and spent time in clearing his lungs every morning and evening. Hari tried this for a couple of days and found it tedious, dull and boring. He gave up lung toilet. Over the next five years, Thomas had no major lung infection, whereas Hari was treated eight times with antibiotics and admitted to the hospital twice with 'severe pneumonia complicating bronchiectasis'.

Comments

In most chronic health problems, simple measures will help prevent or delay the complications. Advice on diet, exercises and lifestyle changes (also called non-drug therapy) belong to this category. Plodders like Thomas usually do well, while procrastinators like Hari, who wait for the right time and mood to comply with the advice, fall behind and deteriorate.

Another feature of many chronic diseases is that they have a life span shorter than the human life span. For example, tuberculosis, if detected early and treated meticulously, can be cured in six months to a year. Hyperthyroidism (excessively functioning thyroid gland) may subside in two to five years. I have seen patients of rheumatoid arthritis, asthma, allergic diseases and fits end with inactive "burnt-out" stage of the disease. Subsequently, they have survived for many years with acceptable quality of life.

Two messages for coping with chronic diseases:

i) Grin and bear it. The disease usually has a shorter life span than you have!

ii) Meticulous and steady control measures help you to reach the finish line in chronic diseases. Be a plodder like the tortoise and win the race against the disease!

41. Fantasizing

The Milkmaid and her Pail: *A farmer's daughter milked the cows and was walking with the pail of milk on her head. She started imagining how her future would be. "The milk will give me cream. I will make butter with that. I will sell it and buy many eggs. When the eggs hatch, I will get*

chicken. By and by I shall have large poultry. When I get enough money from the poultry, I shall buy fine clothes and go to the annual fair. All the young men will be after me to ask me to love them, but I shall shake my head and say no." Thinking thus, she shook her head and, alas, the pail fell off and all the milk was wasted.

Case A

Chandra, a 36-year old housewife with troubled marriage, read an article on 'Mitral valve prolapse syndrome' (MVP). It is a common condition of redundancy of the valve and affects the heart valves of about 5% of the population. She thought all her symptoms of palpitation, dizziness, lassitude and occasional chest pain fitted with MVP.

She started 'doctor shopping' with a copy of the article to find some one who would confirm her suspicions. However, clinical examination and laboratory tests did not show any valve problems. A doctor told her to consult a marriage counsellor or a psychiatrist for help. Then she got offended and complained about the 'rude behaviour' of the doctor to the medical superintendent of the hospital.

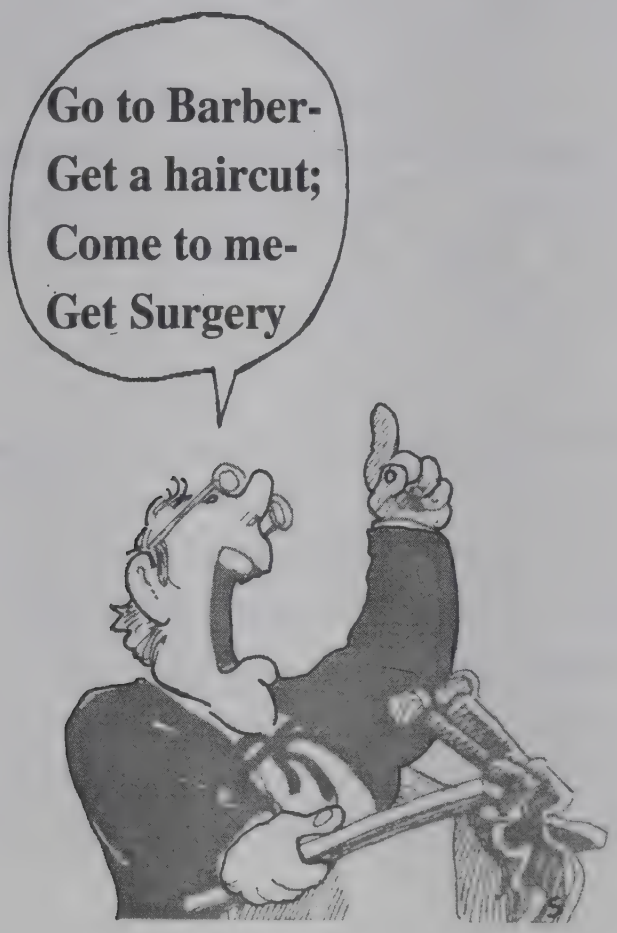
Comments

About 40% of the symptoms seen in family practice, result from unhappiness and stress rather than any disease entity. It is easier for some people to fantasize and medicalise unhappiness than sort out the real problems causing unhappiness.

In the movie 'Throw away wives', the leading woman imagines that her sagging body is the cause of her marriage falling apart. She goes to a cosmetic surgeon for 'uplift surgery'. He asks, "Which one?" She says, "Face, abdomen,

breasts... the whole works." He thinks for some time and replies, "Do not think you can resurrect a failing marriage by uplifts. Go to a marriage counsellor. After six months, if you still feel uplift-surgery is essential, then come back to me. I shall help you."

An average surgeon might have thought "If I do not operate on her, some one else will do it," and taken her up. In the current scenario of free-market and health care industry, it is more common to find '*health care vendors*' who say non-chalantly, "You go to a barber; you get a hair cut. You come to me; you get a prosthesis." Indeed, it takes an ethical doctor with professional pride to educate such persons and not exploit their vulnerability (see ch. 2).



Case B: Sexual fantasy

Dr Bahadur, a dental surgeon, gave Ms Sunita, a 38-year old patient, an intravenous pain killer injection before doing a surgical procedure. To know if she felt any pain, he told her, "You can't speak during the dental procedure. So squeeze me if you feel any pain," and put his left thumb on her right palm and continued his work.

After the procedure was over, he was shocked when Sunita accused him of telling her to squeeze his male organ. She filed a case of indecent exposure and attempted molestation. It was argued in the court that the pain killer drug could cause fantasies and hallucinations in some. As there was a nurse in that room and the door was kept open, Dr Bahadur was considered a victim of circumstances and acquitted.

Comments

A thought for doctors. There are four stages of interpersonal relationship between a doctor and a patient, viz., Clinical, Therapeutic, Personnel and Intimate. The second, therapeutic, is the most satisfying; the fourth, intimate, is the most avoidable.

Sexual hallucination or fantasy may occur due to a variety of reasons. Like in Sunita's case, it could be the side effect of a drug. It may be due to the underlying disease. It may result from misreading the body language or misunderstanding of words with multiple meanings. It may even be a case of "*Meera Syndrome*" where the doctor is elevated to the level of Lord Krishna, worthy of one's love and affection. Psychologists call this transference. At times, a male version of Meera syndrome also occurs. A professional should never take advantage of a client with Meera syndrome to develop intimacy.

Invariably, it is a man who is at the receiving end when a complaint is made, even if he is a patient and the aggrieved woman is a health professional. A male, even when he is a victim of circumstances, is considered to be the 'perpetrator of a misdemeanour' until proven otherwise. Given the ratio of male perpetrators to male victims, perhaps that is how it should be.

How can a male professional protect himself? Young men should remember that *self esteem has neither an age limit nor a beauty-threshold.* They may be careless while handling "elderly" or "bad-looking" women and get a shock when complaints are made of a misdemeanour. Young interns and resident doctors at times get into such situations and then cry, "Madam, you are as old as my mother. How can you accuse me of such a thing?"

Like Caesar's wife, a male doctor has to be above suspicion always. Male health workers and professionals should always keep a female nurse or attender when dealing with a female patient. Prevention is the only cure (see chapter 31).

A male patient getting strong feelings of sexual attraction to a health care worker or professional must realise that it could be just a fantasy, a misunderstanding or a transference reaction. It is better to clear the doubts before doing anything that could land him in jail!

42. Taking a lion's share

The Lion and the Wild Mule: *A lion and a wild mule went for hunts together. The mule will chase a prey and run it down and the lion would then come up and kill it. When it came to sharing the spoil, the lion divided it into three equal portions. He told the mule, "The first portion is for*

the king of beasts - that is for me. The second is my half of what remains. I expect you to offer me the third portion out of regard and respect. Otherwise, you will feel sorry for yourself."

56-year old Sadhasiva Sastry was a temple priest with a modest income. He had a long standing problem of high blood pressure that had resulted in kidney damage and chronic renal failure. He was stabilised on medicines and weekly dialysis. He asked for kidney transplantation to be done for him though he was told to be a high risk case in view of the diffuse blood vessel disease. His elder daughter who was unmarried and 26 years old, was found fit to donate a kidney.

When his relatives went to a nephrologist, he asked them, "Are you sure? Why should he have such a high risk transplantation?"

"So that he can live for a few more years and marry off his two daughters," they replied.

"But after the surgery he will have no money left to spend on their wedding. Moreover, who will offer to marry the young woman with a large surgical scar and only one kidney?"

However, Sastry went ahead with plans to spend all his savings on the surgery. His daughter was taken to the hospital to donate one of her kidneys.

Comments

The expected follow up scene in Sastry's case would have been: his death within a few months due to a complication like a heart attack or a stroke; the family left behind in a state of penury; the operated young woman from an orthodox background, unable to find a suitable and willing groom.

However, in this case, Sastry had a massive stroke two days before the scheduled transplantation and died. The family had some financial resources, the young woman escaped the knife and the stigma of surgery and the eldest son was employed in the temple. I felt that Providence had intervened at the right moment to save the family but some others disagreed with me.

Heads of families often grab a lion's share of family resources for health care, be it the family property, organs of the family members or their time. It takes an astute physician to counsel the members of a family to arrive at the best possible decision for the whole family and not just for the one expecting a lion's share.

Grabbing a lion's share of the health care and health care costs occurs at a macro level in many other ways. Perhaps these are more important to activists than the individual case cited above.

For example, if you study the accounts of any government hospital, upto 90% of its budget may be spent on its employees leaving very little for the public it is supposed to serve. Compared to what is administered to the public, even the drugs made available for its own staff is of special range and quality. The special beds and private wards are often reserved or allotted first to the staff. The paying public has to wait for long periods to get in. One has to be a VVIP or a close relative of the hospital staff to have access to quality health care; in other words, *one has to join the lions to share the spoils.*

Some health professionals in the government service initially build up their reputation by hard work and then turn into 'Lions'. They convert the government hospital beds to *de facto* private beds. They charge hefty fees for service and

refuse to manage non-paying 'worthless cases'. During the 70's, there was a professor in Kerala who used to collect money even to release the body of a patient who died in his ward. Public shaming was done by some activists to expose him to the society.

The recent release of the citizen's charter of health care rights is a belated step in the right direction (See Appendix). Health activists and consumer groups have to push hard to change the current self-serving paradigm of public health care to one that is citizen-friendly and citizen-oriented.

Grabbing a large piece of cake is also a part of private health care industry. Private laboratories and speciality care centres are forced to cough up as much as 60% of user-charges as kickback to those who refer cases. I know of a radiologist at Kottayam, Kerala, who was so disgusted by the avarice of some specialists referring cases for a CT Scan that he quit his lucrative job in the private sector; he joined an ethical non-profit scan centre set up by a trust.

How to beard these lions in their own dens and curb their avarice is a question that needs serious thinking and follow up action by planners, activists and regulatory bodies.

43. Chasing trivia

***The Bull and The Mouse**: Once a bull was resting after a meal. A mouse was attracted by some food sticking to the nose of the bull. It sneaked up and bit the nose. The bull woke up with a start and chased the tiny mouse. The mouse was too quick to be caught. The bull did not give up and went on with its chase until it was too tired to move. Then the mouse moved close to the bull and said, "Hey! You may*

be very strong and powerful but power and aggression can't solve everything. Live and let live."

Jain, a 30-year old high-flying aggressive business executive, was exasperated by his bowel habits. He consulted many specialists for relief. They performed various tests and told him that there was nothing wrong with his bowels. It was just a 'functional problem'.

He went back to his old family doctor and asked him, "But why can't my bowels move just once a day like all the others? Why should I get disturbed once on waking up and again after each meal? It is shameful that a top-flight executive can't even control his bowels." The family doctor replied, "Mr Jain, there are minor things in life beyond our control. Irritable bowel syndrome is one such problem. Your father has it. Your stressful life will only aggravate it. *Relax and let it be*."

Comments

The motto of Alcoholics anonymous is relevant here:

"To accept the things I can't change,

The courage to change the things I can,

And the Wisdom to know the difference."

There are many trivial health problems which are minor irritants. Allergies, vasomotor rhinitis, tension headache, irritable bowel syndrome, excessive sweating and common cold are some examples. One can adopt a 'bullish approach' of aggressively dealing with them only to find out that your efforts were of little help in tackling the irritant. When confronted with a persistent health problem, you have to ask yourself these questions:

- Can I / Should I
  - modify the illness to preserve my life style?
  - modify my lifestyle to suit the illness?
  - modify both to find an acceptable compromise?
- Are the effort, time and expense involved in making these changes worthwhile?
- If not, should I *just let it be*?

44. Doing too much

The Boy and the Filberts: *A narrow-necked jar was full of filberts. When a boy put his hand into the jar and tried to take a fistful of filberts, his hand got stuck inside the jar. Unwilling to lose the nuts and unable to pull out his hand, he started crying. A bystander, who realised what the problem was, told him, "Don't be so greedy, young boy! Be content with a few nuts and you can easily pull out your hand."*

Mr Saxena, a busy industrialist, had high blood pressure that was difficult to control. He also had recurrent episodes of headache. His doctor told him, "These are stress related. You should take more care of yourself. Take rest." Mr Saxena asked, "How is it possible, doctor? I have to work hard and keep my industries going on full steam." The doctor smiled and replied, "Don't be such an empire builder, Mr Saxena. If you can be satisfied with a smaller and manageable empire, you can improve your quality of life. You will also have less of the stress related health problems."

Comments

Human beings have the desire to be in control: be it Nature, other creatures, other humans or one's own body. It cannot always succeed. The laws of ecology states -

- *Everything is connected to everything else.*
- *Everything must go somewhere.*
- *Nature knows best.*
- *There is 'no free lunch' (Every action extracts a price).*

Beyond a point, more work often means less success. We must apply Einstein's formula (Parkinson's version) in our lives. It states:

$$S = X + Y + Z$$

where S = Success
X = Hard work
Y = Play or rest
Z = Silence

This simple formula is one with profound implications. The human body and mind need hard work for achievement, play or rest for self renewal and periods of silence or solitude to gain insight by mature thinking (C Northcote Parkinson).

In our own lives, we have to find our threshold levels of tolerance for stress. Within that limit stress is a positive motivator and goads us into action. Any stress beyond that limit may mean less in terms of health, joy of living and quality of life.

Several studies have shown that the inability of human beings to manage the social, psychological and emotional aspects of life can lead to the development of high blood

pressure, asthma, migraine, peptic ulcer, heart diseases, etc (Cockerham W, 1989).

When would we learn to manage ourselves and our lives better? Do we have to wait until we evolve into a superior species (super man) as enunciated by saint Aurobindo?

45. Crisis management

> ***The Bathing Boy:*** *A boy was bathing in a river and unknowingly got into deep waters. He shouted for help to save him from drowning. A man who was passing by, stopped and began to scold him for being so careless. "Oh, Sir," pleaded the boy, "please save me first and scold me later. I am drowning."*

Comments

The proper action for the bystander of this fable seems so obvious. But in our own lives, when faced with crises, we may choose to pontify or criticise instead of managing the crisis first. Here are two examples.

- When her son returned home in a drunken state with bruises, Sylvia, a pious woman, scolded him and chased him away. Next morning, he was found unconscious on the roadside and taken to a hospital. Emergency surgery was done to remove blood clots around his brain. He died later.
- When his daughter accidentally broke an expensive cut glass, Mani, a school teacher, scolded her so severely that she could not muster enough courage to show him her bleeding hand. After copious and avoidable blood loss, she was taken to a hospital by her mother for treatment.

In hospital settings, some senior doctors rectify any errors committed by the juniors and counsel them later. Many others waste time in reprimanding and this may delay proper treatment to the patient, the ultimate sufferer in this process.

46. Empowerment

The Bee and Jupiter: *When a Queen Bee presented Jupiter with some fresh honey, he promised to give her anything she wished for. The bee asked for stinging power to all the bees to punish men who robbed them of their honey. Jupiter loved human beings and was displeased at this request from the queen bee. However, he kept his word and gave the bees their stings. However the sting was of such a kind that whenever a bee stings a man, the sting breaks off and the bee dies.*

Health and consumer activists were dissatisfied with the exploitative health care practice and campaigned for some power to bring the care providers to the Law and get quick redressal. Many countries passed consumer protection laws to empower health care seekers. Soon it was apparent that many cases were foisted on the doctors to harass or blackmail them. So *a penalty clause was added* that the appellant will be fined heavily for any abuse of power to seek redressal and for lodging frivolous complaints.

Comments

Power and responsibility should always go hand in hand. Power without responsibility corrupts. Responsibility without power renders one vulnerable and defensive. Both the care seekers and providers should have responsibilities with rights

and power with accountability. Activists beware! "Defensive medicine" practised by insecure physicians is the worst thing that can happen to the quality of health care. Every concerned citizen must ensure that it does not happen (see ch. 28).

47. Taking revenge

> ***The Labourer and the Snake:*** *A farmer's son was bitten by a snake and died. The aggrieved father wanted to kill the snake and stood with an axe outside the snake's hole. When the snake came out he aimed a blow and succeeded in cutting off only its tail. The snake hastened back into the hole. The farmer tried to cajole the snake to come out and make peace, actually wanting to have another go at it. The snake said, "I can never be your friend because of my lost tail nor you mine because of your lost son."*

Mr Swami, an advocate, was very active in fighting against the health care providers for consumer redressal. Once, he developed a surgical problem. He consulted many surgeons but no one was willing to take him up. As his was not an emergency problem, he went around from town to town in search of treatment. Every surgeon told him, "Without a basic doctor-patient trust, treatment is not possible. You won't trust me and I can't trust you."

Comments

I pitied Mr Swami. He had a minor bleeding disease that frightened away all prospective surgeons! He was operated at a government hospital after I coaxed my surgical colleague and a close friend to help him out. Swami recovered from the surgery and got well without any problem.

Lack of trust hurts in two ways. The care Provider may adopt defensive medical practice. The care seeker loses the power of faith and trust in healing process (see 'faith healing' in ch. 14).

Consumers! Choose your doctor with much care and caution. Once chosen, have faith and build up rapport and mutual trust with him/her. It is for your own good.

48. Like a *Dog in the Manger*

> ***The Dog in the Manger:*** *A Dog was lying in a manger on a haystack. When the cattle came into the manger to eat the hay, the dog barked at them and chased them away. "What a selfish animal," the cattle thought, "he can't eat hay and yet he will not let us eat it."*

It was reported in the media that the health care service in India was urban oriented. Rural areas were grossly deficient in modern medical service. One State responded with a 'village health guide' scheme to try and provide at least an elementary health care in villages. The medical officers' association went on a strike and paralysed the health services to get the scheme revoked.

Comments

The British Medical Journal *(1986;293:317)* has said, "The social crime of not entering themselves and forbidding others to enter is like a dog in the manger. Doctors do not care for non curative, less glamorous aspects of primary health care in rural areas."

We should at least find a way of providing basic primary health scheme in villages. Unless it becomes a political agenda

with mass support from the rural electorate, it cannot dislodge 'the dog from the manger'.

There is yet another kind of 'dog in the manger' in public hospitals. I know some senior and "respected academicians" who have behaved like the dog in the manger. They lock up all the new equipment that they do not know how to handle, to prevent the more competent junior staff from gaining attention and getting credit for their skills. The only thing that comes to the rescue of the junior staff is the compulsory age-related retirement. Such unacceptable behaviour needs to be curbed by performance audits and effective regulations in the public sector.

49. Irrational action

> ***The mule and his Rider:*** *A rider was guiding his mount, a mule, along a mountain track. Suddenly the mule left the track and rushed to the edge of a precipice. The rider dismounted and tried to pull the mule back by its tail but it would not budge. Coaxing and cajoling did not help either. Finally, the rider gave up saying, "If you want to jump over the brink, have it your way. It is the quickest way to die."*

Kittu, a 20-year old farm-labourer, was admitted with acute meningitis, a severe infective condition attacking the membranes covering the brain. If untreated, it is a fatal condition. He was admitted in the emergency ward and intensive antibiotic therapy was begun. From an unconscious state, he improved to a delirious state within 24 hours. His parents were upset by his delirious muttering and wanted to take him home 'before he died'.

The treating physician pleaded with them to continue treatment and said, "I can most certainly cure him within a week or two. But if you take him home, he will die within the next three days. Please give us a chance to save his life." The parents refused and took him home against medical advice.

Comments

One of the strong points of modern allopathic medicine is the successful treatment of acute life-threatening infections like pneumonia, meningitis, etc. It is most disheartening for a physician to send against-medical-advice, a patient with a serious but highly curable infection. Such foolish behaviour by the relatives of a sick patient is not uncommon. Dependent persons like women, female children and the elderly are especially vulnerable to such acts by their domineering and boorish relatives.

I have treated a few women patients with potentially curable diseases, whose husbands will sign the against-medical-advice form and take them home. Some callous remarks from these men include:

- "Why should I donate blood for her? I can have my blood and marry some one else."
- "Why should I keep her here? If she dies here, I can't pay for her transport and conduct her funeral. If she dies at home, it is all right. I can manage the funeral."
- "God has given her the infection. Let him decide if she would live or not. I shall take her home and pray."

When confronted with cases like Kittu, I feel that *state custody for health care should be permitted even for adults who, like Kittu, are not in a position to decide for themselves what is good for them*. They are at the mercy of relatives. Cynicism,

fatalism, escapism, or fear of an adverse outcome in a hospital setting, are some of the reasons for the relatives making foolish decisions that can be considered as a form of *'passive homicide'*.

In USA, a country that advocates individual autonomy very strongly, a physician can request the State to take custody of a minor if the parents do not seem to act in the best interest of their child's health.

Our society needs to take a serious look at the thousands of innocent victims who die, not due to lack of quality health care but due to denial of life saving treatment. *We can save many of these women, children and dependent adults from 'passive homicide'*. Plugging the loopholes in health care rights would help. Let us do it soon.

50. Late reaction

> ***The Cage-bird and the Bat:*** *A caged singing bird used to sing at night and be silent during the day. A bat was curious to know why this happened and asked the singing bird. "When I was singing in the day, a bird-catcher set his nets and caught me. If only I had kept quiet then I would not be wasting my life in this cage. Since then I sing only at night." The bat observed, "It is no use keeping quiet in the day now when you are already in the cage. You should have done it earlier and remained free."*

Mr Prasad, a 60-year old man, met Noor Muhammad, his old friend in a park and exclaimed, "Hey, Noor! You have no cigarette in your hand. How come?"

"I have given them up, Prasadji," replied Noor.

Prasad tried to pull his leg, "For the umpteenth time and for 24-hours only."

"No. This is for real. I cannot resume it." Noor appeared sad but determined.

"Why, what happened?", Prasad was concerned now.

"My doctor says all the blood vessels of my legs are blocked. If I don't stop smoking, I will get gangrene of legs. Then they will have to chop off my legs. Better to knock off a bad habit than parts of your body - what do you say?" Noor ended with nervous laughter.

Prasad said, "My dear friend, you would not listen to me for the last 35 years. If only you had done so, your legs might have been free of disease now."

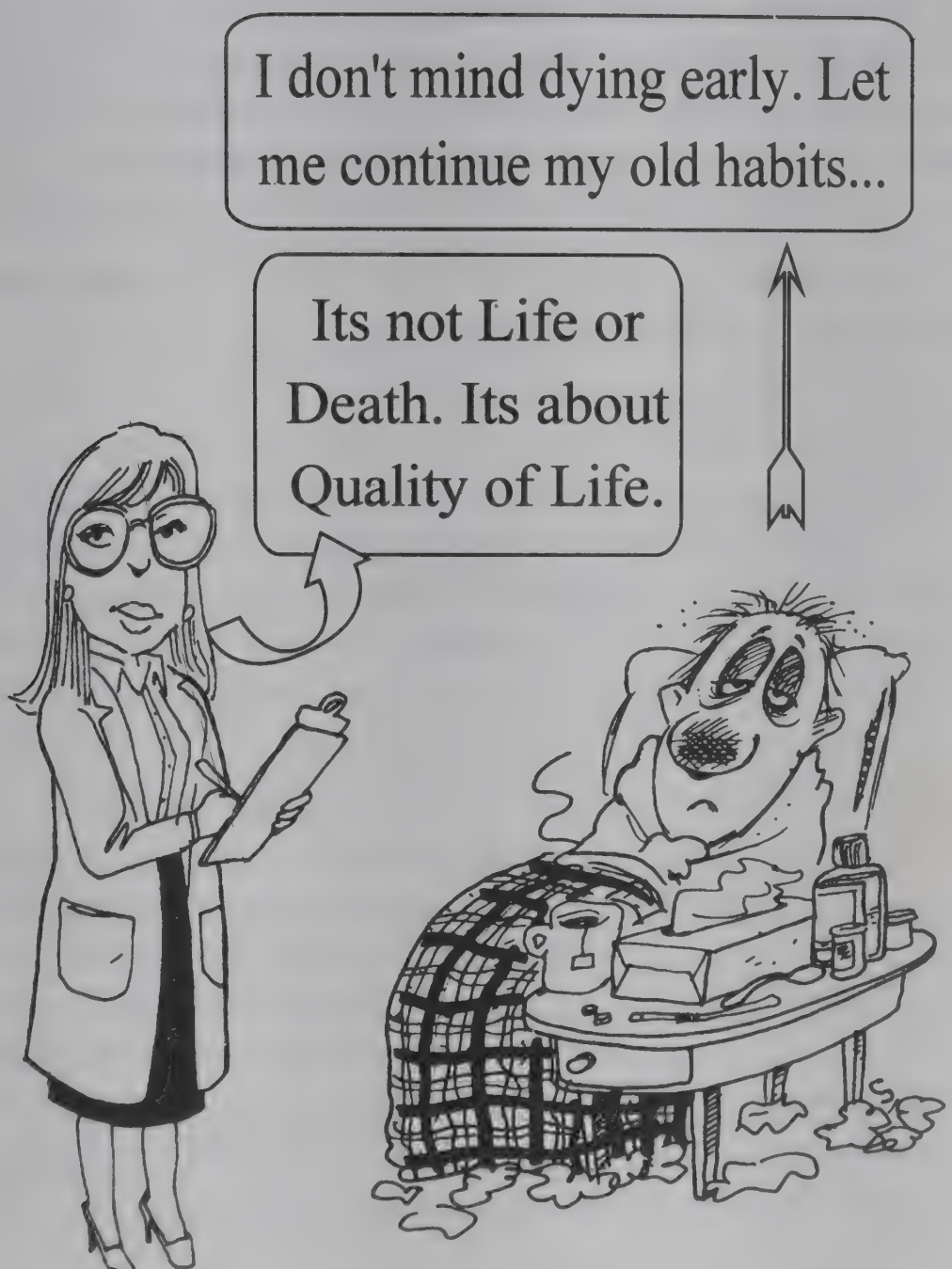
Comments

Late reaction to health hazards like smoking, drinking and promiscuous behaviour is common in the society. When I suggest risk reduction to my patients, they often say, "Doctor, even if I live a few years less, it is OK. I can't give it up."

What they do not realise is that it is not just "living a few years less." More often, it is a question of quality of life. The smoker in the story gave up smoking when he could not walk ten metres without getting pain in the legs. I know many others who stopped smoking after getting a heart attack or more unfortunately, lung cancer.

There was an elderly diabetic who refused to take insulin injections and preferred 'to die early than take injections'. However, he had to change his mind when he lost power of the hip muscles - a well-known reversible complication called

diabetic amyotrophy. I told him, "Your choice is not between life and death. It is between walking and moving around on a wheelchair." After two days, he hesitantly took his first shot of insulin injection. He walked home three weeks later and then took insulin for eight years more until his death.



I have treated an alcoholic who wanted to keep on drinking till he died, but changed his mind once he developed alcoholic neuropathy, and could no longer control his bladder and bowel. Fortunately, his problem resolved with treatment. Now he is a converted man.

Now-a-days, I tell similar patients that there is always a *threshold for suffering* when even the most committed addict will give up the habit. Sometimes they listen to the warning. Often they wait for their own 'suffering-threshold' to be revealed. Perhaps a late reaction is better than no reaction! It is infinitely better to be proactive by 'looking before a leap' and by learning from others' misfortunes.

51. Holding a mirror

The king's order: *Once a poet sang praise of the subjects of a kingdom for being so upright and honest. The king and all the subjects were delighted but the court jester told the king, "Sir! I do not agree with the poet. Your subjects behave well because you do not permit them to behave in any other way. Relax your rules and you will see their true nature. The king reflected on this profound statement.*

A few weeks later, the king ordered every household to pour one pot of milk into the temple tank before the sunrise. Since it was for performing religious rites, no guard would supervise it. Every one thought that he/she would pour a pot of water in the dark so that no one would notice it and it can't be detected later. It was a matter of collective shame when the king arrived at dawn to see the tank full of pure water with absolutely no milk in it!

The teachers of pharmacology - the study of medicines - taught only rational treatment to their students. Since irrational drugs were not taught, they expected that all was well with the quality of prescribing by their students who became practising doctors. It was a revelation to them when a survey revealed two-thirds of the medical prescriptions to be irrational. Further unpleasant revelations surfaced when the supreme court said that even modern allopathic doctors indulged in prescribing medicines belonging to other systems and that such cross-practice amounted to nothing more than quackery. Such a practice was declared illegal and a punishable offence.

Comments

An audit holds a mirror to see ourselves as we are. It helps us to see the true nature of things as they exist in practice, take stock of the situation and plan corrective measures, if needed. A true audit should be like what the king did - the target should have the freedom to behave as they want. Otherwise, the true picture will never emerge. Our health ministers make well-publicised visits to health facilities and never get to see the true picture. Perhaps, they do not wish to face the ugly side of reality.

A medical audit should not be used to conduct witch hunts. Then the stake holders will ensure that results of the audit are as truthful as an income-tax return. The results of the audit should be revealed for introspection, brain-storming and for any corrective action for the future. If any individual is found wanting, he/she may be counselled in private.

The study by Foundation of Research in Community Health on the supply and use of drugs in Satara district of Maharashtra is an example of holistic and broad based drug audit (Phadke A

et al, 1995). The current trends in drug use are quite disturbing. For instance, wasteful annual expenditure on unnecessary drugs is estimated to be about Rs 170 million per year in that district.

If the current medical practice has to improve, the medical councils should be proactive, conduct periodic audits and adopt corrective measures to curb any 'unhealthy trends' detected. As the jester told the king, *bad habits are curbed by regulations*.

On the other hand, *good habits are promoted by the professional groups*. Every professional body should introspect and promote professional behaviour that is good for the society. The Indian Academy of Paediatrics has shown the way. It is time that others, especially the tertiary specialities, joined in the movement of introspective self cleansing (see ch. 26).

52. Seeing the whole picture

The Blind Men and the Elephant: *When a group of blind men were shown an elephant, each touched different parts of its body.*

One said, 'It is like a rope'.

Others disagreed and said:

"No! It is like a thick snake."
"No! It is like a tree trunk."
"No! It is like a fan."
"No! It is like a spear."
"No! It is like a wall."

The guide with a normal vision then told them, "You are all partly right but wholly wrong" and described to them the size and parts of the elephant.

Kannan, a 56-year old toddy tapper, went to a heart care centre for advice. Of late, he had developed chest discomfort while climbing tall palm trees to collect toddy. He had adapted to this disability by climbing on dwarf palm trees and delegating the tall trees to his son. On testing, he was found to have blood flow problems in the heart (ischemia).

Dr Shankar, a heart specialist of the centre, suggested that it is better to ask Kannan to stop climbing trees and manage his cardiac symptom with medications. A surgeon disagreed and asked Shankar, "What will he do for living?"

"Why, he could sell some eatables in front of a toddy shop. He won't have symptoms then." Shankar replied.

The surgeon laughed derisively and said, "We should do our best for this case. In similar cases, Western literature clearly says that surgical treatment is better than medical treatment. Only surgery can put him back on his job of toddy tapping." Some others agreed with this line of thinking. Anyway, they were badly in need of cases for coronary bypass surgery; an expert surgeon was due to arrive shortly to operate on cases and boost the image of the cardiac centre.

Kannan was operated and sent home. He came for a check up ten weeks later. Dr Shankar spotted him and called him to his consulting room. "Kanna, How are you?", he asked.

"Doctor sir, by God's grace, I have survived the operation and I am fine."

"What do you do nowadays? Do you climb trees?"

"No, sir, how can I do that?"

"But, you were operated upon so that you can again climb tall trees once again and tap toddy."

Kannan replied, "Sir, you have spent so much money on me, operated on me; you have kept me in intensive care for two days and given me a new lease of life. I have had a rebirth. My life is now so precious. I can't risk it by climbing trees. I do not even climb the dwarf trees anymore."

Dr Shankar was bemused. "Then how do you earn a living?" he asked Kannan.

"Sir, I sell salted peanuts in front of a toddy shop."

Comments

Dr B. Lown, the co-founder of International Physicians for the Prevention of Nuclear War, for which he got the Nobel Peace Prize, writes, "The focus of the (health care) system as it has become an industrial behemoth, has shifted from attending to the sick to guarding the economic bottom line, putting itself on a collision course with professional doctoring" *(Lown B. 1996)*.

When economy of the health industry is the priority, holistic approach takes a back seat. After all, six "blind specialists" groping on different parts of a case generate much more income than a holistic physician identifying the whole problem with a proper perspective.

Hippocrates said, "*I would like to know what type of person has a disease more than what type of disease a person has.*" This sums up holistic perspective concisely. The 'life world' of a person influences the disease, the care seeking process and even the healing process. Yet it is ignored by most physicians.

In a tertiary care setting, disease orientation is the norm and person orientation is the exception. Professionals like Dr Shankar, are gently told that they belong to 'family practice or

something like that' and eased out of tertiary care setting.

This is a very unfortunate development especially in the third world. I have seen many persons with acceptable quality of life sacrificed at the altar of hi-tech disease care.

I have also seen asymptomatic teenage girls with small or medium sized "holes in the heart" undergo open heart surgery to close the holes. Left alone, these rural, semi-literate young women from orthodox families would have got married, settled in life, produced children and may or may not get into late complications after the age of forty. They could have been followed up and if necessary, operated later around the age of thirty years. But they are treated like young women in the West and therein lies the problems they face in their life-world.

Scarring them on the chest wall and the hospitalisation stigmatises them in their community. Some do not get married and continue to be a "family-burden." Some others get married only to be scolded and sent back when the husbands discover the scar and the details of a heart operation concealed from him before the wedding. These young women also return to their parents and end up as a "family burden." It is only a fortunate few who are well settled in life after undergoing such surgeries. Meanwhile, the heart centre will claim that 95% of the cases are "successfully treated" because, success in their paradigm means a well closed "hole in the heart".

Should we focus on *the hole in her heart* or *the whole of her life* is a fundamental and complex query which needs a holistic approach. Hi-tech assembly-line medical care does not usually allow such debates. This has to be done at the primary care level by the family physician. If holistic perspective of a case suggests that a tertiary care procedure is not warranted, then

such a case should not be allowed to enter the assembly line of a tertiary care facility. This is an ethical obligation expected of holistic primary care physicians. (EQUIP model, 1995)

Where are such physicians? If you find one, engage him/her as your family doctor for life. Such a person will not trick you but treat you in a wholesome manner.

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Appendix - 1

EMERGENCY SERVICES IN HOSPITALS

[Extract of letter No.Z.28015/131/96-H, dated 13-12-1996 from the Ministry of Health and Family Welfare, Govt. of India, New Delhi]

The Honourable Supreme Court in their judgement dt 6-5-96 in SLP (C) No.796/92 - Paschim Banga Khet Mazdoor Samity and others Vs State of West Bengal and another suggested remedial measures to ensure immediate medical attention and treatment to persons in real need. The State Government of West Bengal alone was a Party in the proceedings of the case. The Hon. Court has given directions that other States though not parties should also take necessary steps in the light of recommendations made by the Enquiry Committee which was set up by the State Government of West Bengal and further directions as given by the Court.

The following guidelines may also be kept in view while dealing with emergency cases in addition to the existing guidelines:-

i) In the hospital, the Medical Officer in the emergency/Casualty services should admit a patient whose condition is morbid/serious in consultation with the specialist concerned on duty in the emergency department.

ii) In case the vacant beds are not available in the concerned department to accommodate such patient, the patient has to be given all necessary attention.

iii) Subsequently, the Medical Officer will make necessary arrangement to get the patient transferred to another hospital in the Ambulance. The position as to whether there is vacant bed in the concerned department has to be ascertained before transferring the patient. The patient will be accompanied by the resident Medical Officer in the Ambulance.

iv) In no case the patient will be left unattended for want of vacant beds in the emergency/Casualty Department.

v) The services of CATS should be utilised to the extent possible in Delhi.

vi) The efforts may be made to monitor the functioning of the emergency department periodically by the Heads of the institution.

vii) The Medical record of patient attending the emergency services should be preserved in the medical record department.

viii) The Medical Superintendent may coordinate with each other for providing better emergency services.

3. With regard to maintenance of admission register of patient, following may be kept in view:-

a) Clear recording of the name, age, sex, address and disease of the patient by the attending Medical Officer;

b) Clear recording of the date and time of attendance, examination/admission of the patient;

c) Clear indication whether and where the patient has been admitted, transferred, referred;

d) Safe custody of the Registers;

e) Periodical inspection of the arrangement by the Superintendent;

f) Fixing of responsibility of maintenance and safe custody of the Registers.

4. With regard to identifying the individual medical officer attending to the individual patient approaching OPD/emergency department of a hospital on the basis of consulting the hospital records, it has been directed by the Court that the following procedure should be followed in future:-

a) A copy of the Duty Roster of Medical Officers should be preserved in the Office of the Superintendent incorporating the modifications done for unavoidable circumstances;

b) Each Department shall maintain a register for recording the signature of attending medical officers denoting their arrival and departure time;

c) The attending medical officer shall write his full name clearly and put his signature in the treatment document;

d) The Superintendents of the hospital shall keep all such records in safe custody.

e) A copy of the ticket issued to the patient should be maintained or the relevant date in this regard should be noted in an appropriate record for future guidance.

It is appreciated that Hospital Superintendent/Medical Officers-in-charge may have difficulty in implementing these guidelines due to various constraints at the ground level and as such, feedback is vital to enable Government to refine and modify the order as it will ensure a valid working plant to regulate admission on a just basis. Detailed comments are, therefore, requested with constructive suggestions.

Appendix - 2

MODEL CITIZEN'S CHARTER FOR GOVERNMENT HOSPITALS

[Extract of letter No.Z.28015/29/97-H(i), dated 17-6-97 and D.O.No. Z.28015/29/97-H(iv), dated 25-6-97 from the Ministry of Health and Family Welfare, Govt. of India, New Delhi]

1. Preamble:

Government hospitals exist to provide every citizen of India with health care within resources and facilities available. Such care is to be made available without discrimination by age, sex, religion, caste, political affiliation, economic and social status. This Charter seeks to provide a framework which enables citizens to know what services are available, the quality of services they are entitled to and to inform them about the means through which complaints regarding denial or poor quality of service will be addressed.

2. Objectives:

2.1 To make available medical treatment and related facilities, for citizens who seek treatment at the hospital,

2.2 To provide the appropriate advice, treatment and support that would help cure the ailment to the extent medically possible,

2.3 To ensure that treatment is based on well considered judgement, is timely and comprehensive and with the consent of the citizen being treated,

2.4 To ensure users awareness of the nature of ailment, progress of treatment, duration of treatment and impact on their health and lives, and

2.5 To redress any grievance in this regard.

3. Components of service at hospitals:

3.1 Access to hospitals and professional medical care to all,

3.2 Making provision for emergency care after main treatment hours, whenever needed,

3.3 Informing users about available facilities, costs involved, and requirements expected of their with regard to treatment as well as use of hospital facilities, in clear and simple terms,

3.4 Informing users of equipments out of order,

3.5 Ensuring that users can seek clarifications on and assistance in making use of medical treatment and hospital facilities,

3.6 Collecting fees and charges that are reasonable and well known to public, and

3.7 Informing users about steps to be carried out in case of most of the common deficiencies in service.

4. Commitments of the Charter:

4.1 To provide access to available facilities without discrimination,

4.2 To provide emergency care, if needed, on reaching the hospital,

4.3 To provide adequate number (to be defined) of notice boards detailing location of all facilities,

4.4 To provide written information on diagnosis, treatment being administered, and costs that will be recovered, each day in case of in-patients,

4.5 To provide a receipt of all payments made for medical care,

4.6 To record complaints round the clock, and designate Medical Officers who will respond at an appointed time the same day in case of in-patients and the next day in case of out-patients.

5. Grievance redressal:

5.1 Grievances that citizens have will be recorded round the clock.

5.2 There will be a designated medical officer to respond to requests deemed urgent by the person recording the grievances.

5.3 Aggrieved users would, after having their complaint recorded, be allowed to seek a second opinion from within the hospital.

5.4 Have a Public Grievances Committee outside the hospital to deal with grievances that are not resolved within the hospital.

6. Steps that will be taken:

6.1 Hospital staff, Department of Health and citizens representatives will discuss the utility and content of the Charter before it is formulated.

6.2 The areas on which standards are prescribed will be selected on the basis of feedback from users of problems and deficiencies, collected by an independent body.

6.3 Systematic efforts will be made to create wide awareness that a Charter exists, among the users of the hospital, and

6.4 Performance in areas where standards have been specified in the Charter will be compiled and displayed publicly.

7. Responsibilities of the users:

7.1 Users of hospitals would attempt to understand the commitments made in the Charter and demand adherence,

7.2 Users would not insist on service above the standards set in the Charter, particularly because it could negatively affect the provision of the minimum acceptable level of service to another user,

7.3 Instructions of the hospital personnel would be followed sincerely, and

7.4 In case of grievances, the redressal machinery would be addressed by users without delay.

8. Feedback from the users:

8.1 The perceptions of users on the quality of service of hospitals would be systematically collected and analysed by an independent agency, and

8.2 The feedback would cover areas where standards have been specified as well as other areas where standards are proposed to be set up.

9. Performance audit and Review of the Charter:

9.1 Performance audit may be conducted through a peer review every year or every two years.

9.2 The audit would look at user feedback, records on adherence to committed standards, the performance on parameters where standards have not yet been set, and other indicators of successful goal realisation.

9.3 Identify areas where standards can be introduced, tightened, etc., opportunities for cost reduction, and areas where capacity building is required, and

9.4 Through re-assessment of the contents of the Charter every five years.

INDEX

THIS BOOK IS MEANT FOR YOU !

☞ If you are a **Reader** who wishes to -

- Be aware of various tricks played on gullible persons seeking health care and be smarter.

☞ If you are a **Woman** who wishes to -

- Be aware of gender related risks in hospitals and know how to avoid sexual harassment.

☞ If you are an **Activist** who wishes to -

- Learn to discuss the pros and cons of multi-faceted health care issues?

☞ If you are a **Health Professional** who wishes to -

- See the current health crises from client's view point and learn to avoid litigations.

☞ If you are an **Administrator** who wishes to -

- Understand the complex nature of health care related problems in our country?
- Realise how synergy and co-operation among the key players of health care is necessary to improve the current dismal scene?